

**Annual Report
On The Department Of Human Services'
Implementation Of Programs
To Address Uninsurance
Among Rhode Islanders**

Submitted to:

Permanent Joint Committee on Health Care Oversight

Submitted by:

Ronald A. Lebel, Esq.
Acting Director
Rhode Island Department of Human Services

February 15, 2006



DEPARTMENT OF HUMAN SERVICES

Office of the Director

February 9, 2006

The Honorable Elizabeth H. Roberts
Co-Chair, Permanent Joint Committee on Health Care Oversight
State House, Room 313
Providence, RI 02908

The Honorable Steven M. Costantino
Co-Chair, Permanent Joint Committee on Health Care Oversight
State House, Room 306
Providence, RI 02908

Dear Senator Roberts and Representative Costantino:

As required under Section 40-8.4-14, the RItE Care Stabilization Act of the Health Reform Rhode Island 2000 Act, the Department of Human Services respectfully submits this annual report entitled, "Implementation of Programs to Address Uninsurance Among Rhode Islanders," to the Permanent Joint Committee on Health Care Oversight. This report provides an overview of the progress we have made and the challenges ahead.

Since the legislation was enacted, the Department has vigorously moved forward to meet the goals of the Act. We have been able to continue the success of RItE Care by assuring access to accountable, quality health care services for low-income Rhode Island families. RItE Care has continued to show significant improvements in health services access, quality and health outcomes.

At the same time, we have emphasized fiscal responsibility in the expenditure of public dollars by successfully meeting the objectives and intent set forth in Health Reform 2000:

1. RItE Care enrollment has stabilized while enrollment in RItE Share has grown;
2. As of June 30, 2005, 5,796 individuals were enrolled in employer sponsored insurance through the RItE Share premium assistance program, rather than in full cost RItE Care, at a projected savings of \$5,059,676 in FY05 (\$1,653,285 general revenue);
3. As of the beginning of state FY05, 1,036 employers were approved for participation in RItE Share, compared with 117 employers in January 2002;

4. Requiring monthly family cost sharing for 5,392 RItE Care and RItE Share enrolled families achieved \$3,789,104 in savings in FY05 (\$1,684,636 in general revenue);
5. In 2004, the level of uninsurance was 11.4% overall and 7.4% for children. Rhode Island had the ninth lowest rate of overall uninsurance in the nation in 2004, the most recent year for which data are available.

The report also describes the successful transition of children with special health care needs and in foster placement from fee-for-service Medicaid into RItE Care. This change in health care delivery for children with special health care needs will improve access to preventive, primary and mental health care, while decreasing reliance on higher cost institutional-based care.

RItE Care and RItE Share continue to be heralded as national models for addressing uninsurance, improving quality and health outcomes, and containing state costs. I am attaching a short list of recent articles that document the success of RItE Care in providing cost effective, quality health care for children and families in Rhode Island.

I look forward to working with the Committee on these and other issues of importance to our State.

Sincerely,

Ronald A. Lebel, Esq.
Acting Director

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TABLE OF CONTENTS

	<u>Page Number</u>
I. Introduction	2
II. Rhode Island Uninsurance Trends	7
III. RItE Care for Children and Families	10
IV. RItE Share for Children and Families	21
V. Cost-Sharing for Children and Families	25
VI. RItE Care for Children with Special Health Care Needs	27

Appendices

- A. *The Impact of RItE Care on the Health of Pregnant Women and Their Newborns, 1993-2003* July 2005
- B. *Profiles and Trends of the Uninsured in Rhode Island: 2004 Update* November 2005
- C. *Characteristics of Uninsured Rhode Islanders in Three Age Groups* June 2005
- D. *Premium Assistance Programs: How Are They Financed And Do States Save Money?* October 2005

I. INTRODUCTION

In November of 1993, the State of Rhode Island was granted a Section 1115 Medicaid waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called RItE Care. RItE Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

Over the years, RItE Care has continued to evolve in response to the State's experience in operating the program and as a result of national and State policy initiatives. One of the most significant changes in the project has been the increase in the number of populations eligible for RItE Care. RItE Care was initially designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)¹ families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Over time, the populations eligible for RItE Care have expanded, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act through a State Plan Amendment (SPA))

¹Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF), FIP is Rhode Island's program for the TANF-eligible population.

- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL
- Effective December 1, 2000, to maximize enrollment of children in foster care placements² from fee- for-service Medicaid to RItE Care
- Effective November 1, 2002, to establish a separate child health program to cover unborn children with family income up to 250 percent of the FPL
- Effective January 29, 2003, to enroll the following categories of children with special health care needs into RItE Care Health Plans on a mandatory basis³:
 - Blind/disabled children, and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)
 - Children eligible under Section 1902(e)(3) of the Social Security Act (“Katie Beckett” children)
 - Children receiving subsidized adoption assistance

The Section 1115 Medicaid waiver is effective through July 31, 2008.

The May 1, 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Children’s Health Insurance Program, or SCHIP) of the Social Security Act. By Section 1115 SCHIP waiver approval (21-W-00002/1-01), effective January 18, 2001, Section 1931 parents and relative caretakers between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. Approved April 17, 2003, the separate child health program allows the State to provide comprehensive coverage for pregnant aliens who would not be otherwise eligible for Federal financial participation (FFP). These women are enrolled in RItE Care Health Plans. The Section 1115 SCHIP waiver is effective through January 17, 2006, although the State has applied to the Federal Government for a three-year extension of that waiver. When the extension is approved, which the Department of Human Services (DHS) fully expects to occur, the two waivers will be combined for administrative purposes and both will extend through July 31, 2008.

It should be noted that the State received approval from the, then, Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS)) on January 5, 1999 to expand SCHIP coverage to children under age 19 in households with income up to 300 percent of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to ongoing budgetary constraints.

In addition to these covered populations, the RItE Care Health Plans must make coverage

² Children in foster care are in enrolled in RItE Care on a voluntary basis.

³ Children with special health care needs are also presently enrolled on a voluntary basis, as only one Health Plan, Neighborhood Health Plan of Rhode Island (NHPRI) has been willing to enroll this population. NHPRI is also the only Health Plan that has been willing to enroll children in foster care.

available to certain State-funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL
- Children who are uninsured whose household income is in excess of 250 percent of the FPL
- Licensed family child care providers and their eligible dependents

RItE Care has been demonstrably successful in accomplishing its goals – at times, perhaps, too successful. RItE Care's enrollment grew substantially from 1998 through 2001 as a result of four significant and concurrent events described below:

- The State expanded eligibility to parents and relative caretakers of RItE Care-enrolled children up to 185 percent of the FPL, under Section 1931 of the Social Security Act.
- The State streamlined the RItE Care application process, by creating a short, mail-in application in English and Spanish and eliminating face-to-face interviews for both the initial eligibility determination and for re-determination.
- The State embarked on an ambitious community-based outreach campaign to reach and enroll uninsured children and families.
- The State's commercial insurance market began to deteriorate, marked by sharp increases in premium rates offered to employers, reduced competition as a result of two of the State's commercial insurers suddenly exiting Rhode Island, and significant hospital and health plan losses.

Over the same period of time, RItE Care's enrollment grew by 41 percent – from 74,000 in November 1998 to 104,000 by June 2000. Before that time, RItE Care enrollment had remained relatively stable despite the incremental expansions in coverage for children described earlier. The magnitude of the enrollment growth caused unexpected increases in program costs.

While it is still unclear to the State which of these four events contributed most to RItE Care's enrollment growth, it was most likely the combination of all four. It is also unclear how much of RItE Care's growth was due to crowd-out, although to some degree this undoubtedly occurred.

In January 2000, then Governor Lincoln Almond convened a group of Administration staff, legislative leaders, and consumer and business representatives to find a solution to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee (Steering Committee), as the workgroup was called, was convened to be broadly representative of employers, consumers, labor, and the legislative and executive branches of government. Health care providers and insurers were invited to attend meetings and provide testimony to the Steering Committee. During the next six months, the Steering Committee focused on methods to stabilize

the ESI market. Specifically, the Steering Committee examined methods to enable small businesses to maintain ESI by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain ESI. The focus on small employers was due to the increasing number of businesses with less than 50 workers reporting the most volatile rate increases and the resulting difficulty in retaining and/or obtaining ESI, as well as the vital role these employers play in the State's overall economic health.

Governor Almond signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1** – Directing DHS to stabilize the RItE Care program by targeting resources to those most in need of coverage – low-wage families without access to affordable coverage, through:
 - Authorizing DHS to establish eligibility requirements for RItE Care to deter substitution (i.e., a waiting period for new applicants who were enrolled in ESI within six months prior to application)
 - Establishing cost-sharing requirements for certain RItE Care-eligible populations to promote both responsible utilization of health care services and development of additional disincentives for substitution
 - Requiring mandatory participation in RItE Share of eligible individuals and families who have access to ESI. (This was implemented under a separate Section 1906 Medicaid SPA.)
- **Part 2** – Reforming the health insurance marketplace to: (a) conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, (b) stabilize premiums in the small group market by compressing rate bands, and (c) guarantee issue of a basic health plan
- **Part 3** – Establishing new financial reserve requirements for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC)

RItE Share, the State of Rhode Island's premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI), had the following implementation timelines:

- *February 2001* – Initiated voluntary enrollment in RItE Share
- *April 2001* – Began transitioning RItE Care enrollees with access to ESI to RItE Share

- *February 2002* – Began mandatory enrollment in RItE Share of eligibles with access to qualified ESI

The passage of Part 1 of the Health Reform Rhode Island 2000 represented a significant and important consensus between the Governor and leaders in the General Assembly – RItE Care must be consistent with its original mission to provide coverage to the truly uninsured and migration from ESI to RItE Care should be deterred. The Governor and General Assembly were also clear that if the RItE Care caseload and cost growth are not controlled by Part 1 of the statute, a roll-back of eligibility expansions currently in place for working families, particularly the Section 1931 expansion implemented in 1998 for parents and relative caretakers whose incomes are above TANF levels, will be considered.

Section 40-8.4-7 of Health Reform Rhode Island 2000 stipulates:

“The Department of Human Services shall investigate and develop opportunities for individuals and/or employers to buy into, at the individual’s or employer’s expense, one or more programs the department may establish under this chapter or chapter 12.3 of title 42 to address uninsurance among Rhode Islanders, and shall provide a report on such efforts to the Permanent Joint Committee on Health Care Oversight established pursuant to section 40-8.4-14 on or before February 15 of each year.”

This document is the subject report, which is organized as follows:

- Rhode Island Uninsurance Trends
- RItE Care for Children and Families
- RItE Share for Children and Families
- Cost-Sharing for Children and Families
- RItE Care for Children with Special Health Care Needs

In general, program information is reported for State Fiscal Year (SFY) 2005, although some information is reported for the RItE Care “Program Year” (ending July 31, 2005) and for the end of Calendar Year 2005.

II. RHODE ISLAND UNINSURANCE

Uninsurance was an important issue for the State and a motivating factor for implementing RItE Care, with a particular emphasis on uninsured children. RItE Care was ahead of the curve nationally and preceded enactment of SCHIP.

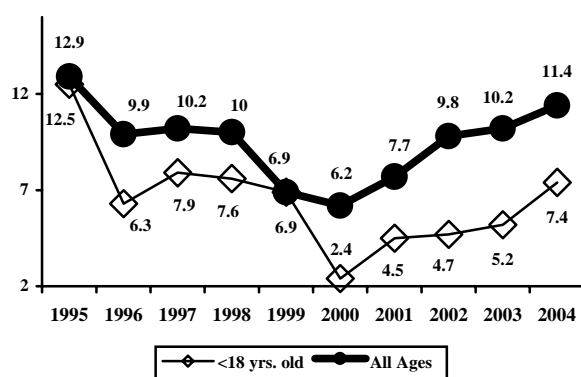
As noted in Chapter I, the State conceived and implemented RItE Care population expansions to reduce the level of uninsurance incrementally, including, where permissible, through use of SCHIP. The time period immediately before enactment of the Balanced Budget Act of 1997 (which included SCHIP) is the reference point for analysis of Rhode Island's success in impacting the uninsurance rate in the State.

According to the U.S. Bureau of the Census⁴, in 1996 90.1 percent of the Rhode Island population was covered by public or private health insurance and 9.9 percent were uninsured. With an estimate of 235,283 children in Rhode Island as of July 1, 1996, this means that there were an estimated 23,500 without health insurance coverage as of July 1, 1996.

According to the most recent *Current Population Survey* (CPS)⁵, the level of uninsurance in Rhode Island in 2004 (the most recent year for which data are available) was 11.4 percent overall and 7.4 percent for children as Figure 1 shows. For the overall rate, Rhode Island had⁶ the ninth lowest rate of uninsurance in the nation.⁷ In 2000, Rhode Island had the lowest uninsurance rate⁸ in the country for both children and the total population. The figure also shows that after experiencing a sustained, declining trend in the level of uninsurance in the State, in 2001 the level of uninsurance increased.

Figure 1

Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2004



⁴Bennefield, R. L. "Health Insurance Coverage: 1996", *Current Population Reports: Consumer Income*

⁵ U.S. Census Bureau. *Current Population Survey*, September 2005

⁶ *Ibid.*

⁷ This rank was down from 2nd the nation in 2003

⁸ Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island, 1995-2002*, RI Medicaid Research and Evaluation Reports, May 2004.

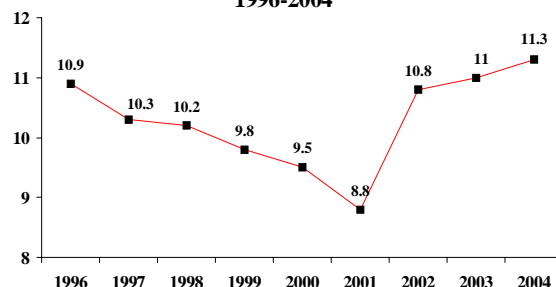
The overall rate of uninsurance in Rhode Island continues to grow and the State's relative rank compared to other States continues to decline as Minnesota, Iowa, Hawaii, Maine, Wisconsin, Kansas, North Dakota and Vermont, respectively, had lower rates of uninsurance in 2004 than did Rhode Island.

The 2002 – 2004 three-year average⁹ showed that Rhode Island had, at 10.5 percent, the sixth lowest rate of uninsurance in the nation behind Minnesota, Hawaii, Iowa, Wisconsin, and Vermont. The State's rate was 32 percent less than the national average of 15.5 percent. The 2003 – 2004 two-year average showed that Rhode Island was, at 10.8 percent, seventh¹⁰ behind Minnesota, Hawaii, Maine, Vermont, Iowa, and Wisconsin, which was 30 percent less than the national average of 15.7 percent. Rhode Island was no longer the national leader in the uninsurance rate for children under age 19 at or below 200 percent of the FPL¹¹, the standard used nationally for SCHIP. The data showed the uninsurance rate for low-income children in Rhode Island in 2004 was 4.3 percent – 13th lowest in the nation¹², behind Vermont, Connecticut, Hawaii, Massachusetts, Maine, Washington, Alabama, Wisconsin, Arkansas, South Dakota, Minnesota, and New Hampshire. Rhode Island's uninsurance rate for low-income children in 2004 was 39 percent less than the national rate of 7.1 percent.

Because of some historical concerns about CPS data and the fact that Rhode Island covers adults under its Section 1115 SCHIP waiver, Rhode Island has been making greater use of the Behavioral Risk Factor Surveillance System (BRFSS) data to examine uninsurance among adults in Rhode Island aged 18 to 64. BRFSS reports on those “uninsured at the time of the phone survey”¹³, with a sample size of more than twice that of the CPS. Figure 2 shows the percent of uninsured adults in Rhode Island was 11.3% in 2004, based on BRFSS data.

Figure 2

Percent Uninsured Rhode Islanders Ages 18-64:
1996-2004



⁹ U.S. Census Bureau, *Op. Cit.*, Table 9

¹⁰ *Ibid.*

¹¹ *Ibid.*, Table HI10.

¹² This rank was down from 7th in the nation in 2003.

¹³ Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: 2003 Update*, RI Medicaid Research and Evaluation Reports, April 2005.

The increased level of uninsurance was due to continued erosion in coverage by employer-sponsored insurance (ESI).

The Department of Human Services (DHS) has also been making increased use of the Health Interview Survey (HIS). The HIS is a survey conducted periodically by the Rhode Island Department of Health. The most recent analysis of HIS data summarizes 1990, 1996, and 2001 survey results¹⁴. In 2001, a random sample of 2,600 Rhode Island households were interviewed by telephone for the HIS, covering 6,877 individuals. Summary findings are as follows:

- The typical demographic characteristics of the uninsured in Rhode Island: is that they are between the ages of 18-34 years of age, male, White non-Hispanic, not married, completed high school or have a GED, low-income, employed, and live in a household of more than three persons
- The population groups that were disproportionately represented, or were more likely to be uninsured, included: Hispanics, unemployed persons, core city residents, and those who lived alone
- Although the employed were insured at a higher rate, most uninsured Rhode Islanders are employed (61 percent). However, the 46 percent of the unemployed were uninsured
- The percent of uninsured children in Rhode Island has declined 50 percent from 8.4 percent in 1990 to 3.8 percent in 2001. Uninsured children were disproportionately represented in the age group 6-12 years of age, which comprised 50 percent of the uninsured children in Rhode Island. Children under 5 years of age had the highest rate of insurance coverage, with only 2.5 percent uninsured.
- The percent of uninsured under 65 years of age in Rhode Island declined from 10.5 percent in 1990 to 7.8 percent in 2001, as did the percent of uninsured women aged 15-44 from 10.9 percent in 1990 to 7.8 percent in 2001
- The majority of the uninsured in Rhode Island are White, while 22 percent were Hispanic. However, 17 percent of all Hispanics were uninsured compared to only 6 percent for Whites.
- Nearly 50 percent of the uninsured in Rhode Island had incomes under 200 percent of the FPL and over 70 percent of the uninsured had incomes below 300 percent of the FPL.

The HIS is being conducted again by the Rhode Island Department of Health this fiscal year.

III. RITE CARE FOR CHILDREN AND FAMILIES

¹⁴ Bogen, K. *Who Are the Uninsured in Rhode Island? Demographic Trends, Access to Care, and Health Status for the Under 65 Population*. RI Medicaid Research and Evaluation Reports, September 2004.

RItE Care has been operational since August 1994. The initial period for the Section 1115 Medicaid waiver for RItE Care was August 1, 1994 to July 31, 1999. On September 17, 1998, the State was notified that its request to extend the waiver period through July 31, 2002 had been granted. On July 29, 2002, the State was notified that its request to extend the waiver period through July 31, 2005 had been granted. On August 31, 2005, the State was notified by the Federal Government that the waiver was extended through July 31, 2008.

On January 18, 2001, the Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS) approved Rhode Island's request for a Section 1115 SCHIP demonstration waiver to allow the State to receive enhanced Federal match for parents and relative caretakers in the Section 1931 expansion group whose incomes are between 100 and 185 percent of the FPL and pregnant women whose incomes are between 185 and 250 percent of the FPL. This approval enabled Rhode Island to receive then 68.77 percent Federal Medical Assistance Percentage (FMAP) in Federal Fiscal Year 2005 for those parents, relative caretakers and pregnant women up to the State's SCHIP allotment (compared to a FMAP for Medicaid of 55.38 percent¹⁵).

3. 1 RItE Care Enrollment Has Stabilized

RItE Care has been operational since August 1994. Enrollment¹⁶ in RItE Care by Health Plan as of the end of the ninth program year (July 31, 2005) is shown in Table 1 below. The RItE Care enrollment at the end of July 2005 was comparable to the RItE Care enrollment as of the end of July 2004 (118,779).

Table 1

Enrollment in RItE Care by Health Plan, As of July 31, 2005

Health Plan	Number Enrolled	Percent
BSBCRI	13,883	11.7%
NHPRI	68,120	57.4%
UHCNE	36,719	30.9%
Total	118,722	100.0%

BSBCRI = Blue Cross and Blue Shield of Rhode Island

NHPRI = Neighborhood Health Plan of Rhode Island

UHCNE = United HealthCare of New England

¹⁵ This is less than the revised 2004 FMAP due to Title V of Jobs and Growth Tax relief Reconciliation Act of 2003 of 58.98 percent.

¹⁶ These enrollment figures do not include children in foster care or children with special health care needs who are enrolled in NHPRI on a voluntary basis. Enrollment of these populations is discussed in Chapter VI.

Enrollment in the RItE Care population expansion groups as of July 31, 2005, in comparison to as of the end of July 2004, is shown in Table 2.

Table 2

RItE Care Enrollment of Expansion Groups as July 31, 2004 and July 31, 2005

Expansion Group	July 31, 2004 Enrollment	July 31, 2005 Enrollment
Parents/ Relative Caretakers up to 185% of FPL	12,089	12,367
Pregnant Women Between 185 and 250% of FPL	79	105
Children up to age 8 up to 250% of FPL	5,452	5,823
Children aged 8 to 19 up to 250% of FPL	10,800	11,328
Extended Family Planning	475	578
Children in Foster Care	2,128	2,180
Unborn Children up to 250% of FPL	487	576

As the next section shows, enrollment in RItE Care has stabilized while enrollment in RItE Share has grown.

In SFY 2005, children under age 18 accounted for 66 percent of the RItE Care caseload in the year. Approximately three-quarters of the adults enrolled were female. Seventy-three percent of RItE Care enrollees were below the Federal poverty level (e.g., \$24,135 for a family of three as of January 1, 2005). Almost twenty-two (21.5) percent of the population spoke a language other than English as their primary language at home. The second most common language, Spanish, was spoken by 18.3 percent of RItE Care members. The majority of RItE care enrollees lived in Rhode Island's core cities – Providence (35.0 percent), Pawtucket (11.3 percent), Woonsocket (6.6 percent), Cranston (5.8 percent), and Central Falls (5.3 percent).

It should be noted that Rhode Island was one of the first four States, along with Minnesota, New Jersey, and Wisconsin, to obtain SCHIP waivers to cover parents/relative caretakers and pregnant women at the higher SCHIP FMAP.

3.2. Administrative Improvements Have Been Made to RItE Care

The State has made a number of improvements over time to make the application and enrollment processes less burdensome, to stimulate enrollment, and to deter *crowd-out* (i.e., substituting public coverage for private coverage). Among these administrative improvements have been the following:

- *October 1998* – Implemented a streamlined mail-in application with minimal documentation requirements and eliminated face-to-face requirements to confirm eligibility

- *April 1999* – Initiated a RItE Care community-based enrollment outreach project, encompassing school-based outreach combined with contracts with 32 community-based organizations using performance-based incentives for locating and enrolling eligible children. This outreach project ended in June 2000.
- *January 2002* – Implemented monthly premiums at up to three percent of income for expansion enrollees over 150 percent of the FPL
- *August 2002* – Increased the monthly premiums but not to exceed five percent of income for expansion enrollees over 150 percent of the FPL
- *May 2004* – Made the RItE Care application available on-line in both English and Spanish

3.3 Delivery System Changes Were Made to RItE Care in 2005

As noted at the beginning of this section, the State of Rhode Island made a policy decision to only allow State-licensed HMOs to participate in RItE Care. There were originally five RItE Care-participating Health Plans: Coordinated Health Partners (CHP, or BlueCHiP), Harvard Community Health Plan (HCHP), Neighborhood Health Plan of Rhode Island (NHPRI), Pilgrim Health Care (PHC), and United HealthCare of New England (UHCNE). There have been several important changes to the Rhode Island HMO marketplace since then. First, HCHP and PHC merged in 1995, becoming Harvard Pilgrim Health Care (HPHC). Second, HPHC left¹⁷ the Rhode Island market without warning in 1999. Finally, Blue Cross and Blue Shield of Rhode Island (BCBSRI) voluntarily gave up its State HMO license at the end of 2004.

In order to assure the availability of choices for RItE Care-eligible individuals, the State changed its policy to allow other than State-licensed HMOs to participate in RItE Care effective January 1, 2005. Non-HMOs must meet the following requirements:

- Be licensed as a health plan in the State
- Be accredited¹⁸ by the National Committee for Quality Assurance (NCQA) as a Medicaid managed care organization (MCO)
- Meet certain State regulatory requirements¹⁹ that HMOs must meet:
 - Have professional services under the direction of a medical director who is licensed in Rhode Island and performs the functions specified in regulation (e.g., oversight of quality management)

¹⁷ Tufts Health Plan of New England also left the Rhode Island market about the same time, although it had never participated in RItE Care.

¹⁸ In Rhode Island, all HMOs must be accredited by NCQA. All three Health Plans have full three-year accreditation and received an “excellent” designation from NCQA. Of all the Medicaid plans in the nation, BCBSRI ranked first, UHCNE ranked third, and NHPRI ranked sixth in 2005. Both BCBSRI and UHCNE have their Medicaid product lines accredited, as well as their Medicare product lines.

¹⁹ *Rules and Regulations for the Certification of Health Plans* (R23-17.13-CHP).

- Make certain enrollees are only liable for co-payments and to have this provision in its provider contracts
- Meet “preventive health care services” requirements and provide them within time frames set by the HMO, according to accepted standards specific to age and gender
- Have a quality management program that is accredited

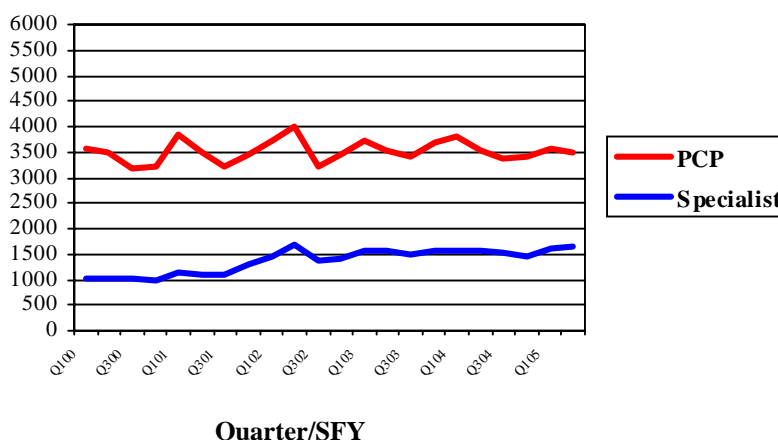
3.4 RItE Care Has Changed Patterns of Care

Not only has RItE Care demonstrably increased the number of low- and moderate-income Rhode Islanders who are insured, but the program has facilitated the ability of enrollees to obtain services and has changed patterns of care. The following illustrates these accomplishments:

- Increased primary care physician (PCP) participation in Medicaid from 350 physicians pre-RItE Care to over 900 physicians post-RItE Care (representing in excess of 90 percent of the practicing PCPs in the State). Every enrollee in RItE Care has a PCP, who is considered the enrollee’s “medical home.” Most specialists in the State also participate in RItE Care.
- Increased average per enrollee physician visits from two per year pre-RItE Care (1993) to five per year through the second quarter of SFY 2005, as Figure 3 shows. It should be noted that visits to health care specialists have averaged two per enrollee per year.

Figure 3

RItE Care Outpatient Visits to PCPs and Specialists per 1,000 Member-Months by Quarter (SFY 2000 - 2005)



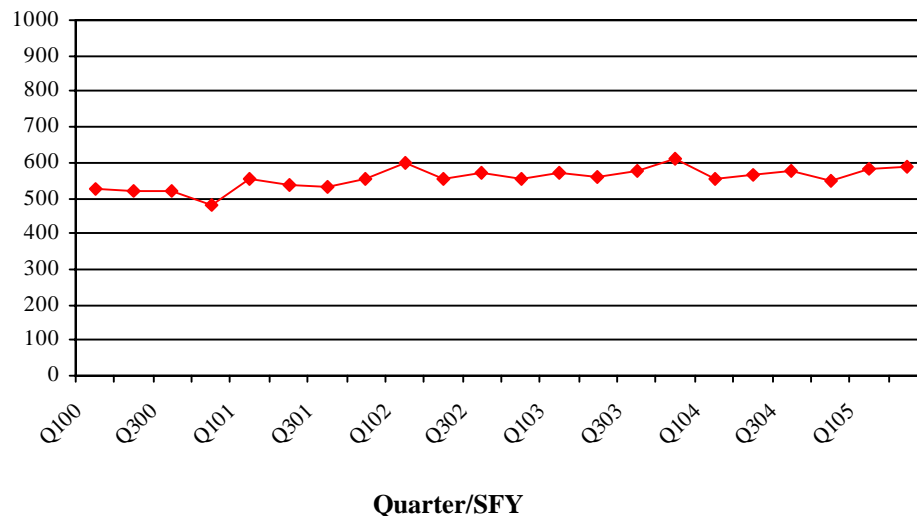
Note: Quarterly rates have been annualized by multiplying by 4

- Decreased hospital emergency department (ED) utilization by more than 40 percent from 1993 to 2000. ED visits, which were 750 per 1,000 Medicaid recipients pre-RItE Care, peaked at about 450 visits per 1,000 enrollees in early SFY 2000. Using the managed

care industry standard of visits per 1,000 member-months, ED visits fluctuated between 500 and 600 per 1,000 member-months. The ED rate peaked at an annual rate of about 600 per 1,000 member-months in third quarter of SFY 2003, and has remained below that level since then. Nonetheless, enrollees who have used the ED report they are satisfied with its accessibility as Table 7 in Section 3.5 below shows.

Figure 4

RItE Care Visits to the Emergency Department per 1,000 Member-Months by Quarter (SFY 2000 - 2005)



Note: Quarterly rates have been annualized by multiplying by 4

- Early entry into prenatal care for pregnant Medicaid women (i.e., in the first trimester) improved significantly from 76 percent in 1993 (pre-RItE Care) to 84 percent in 2003 (RItE Care).²⁰ Although a gap between the Medicaid population and the privately insured population persists, the gap was cut in half from 1993 to 2002.
- Adequacy of prenatal care, as measured by the Kotelchuck Adequacy of Prenatal Care Index, improved significantly for pregnant Medicaid women, from 70 percent in 1993 to 82 percent in 2003 (RItE Care).²¹ Once again, although the gap between the Medicaid population and the privately insured population persists, it was cut by more than 60 percent from 1993 to 2003.

3.5 RItE Care Has Excellent Member Satisfaction

The results of the 2005 RItE Care Member Satisfaction Survey, which had a sample designed to

²⁰ Griffin, J. *The Impact of RItE Care on the Health of Pregnant Women and Their Newborns: 1993-2003*, RI Medicaid Research and Evaluation Project, July 2005.

²¹ *Ibid.*

be effective at a 25 percent response rate (plus or minus 5 percent) in measuring member satisfaction at the RItE Care program level at a 95 percent confidence, are shown below:

Table 3
Overall Member Satisfaction

1996	1997	1998	1999	2000	2001	2003	2004
95.7%	96.5%	96.6%	98.3%	96.6%	98.3%	97.8%	97.9%

- Ninety-eight percent of respondents reported that, overall, they were very satisfied or satisfied with RItE Care. Comparative satisfaction rates from prior surveys are shown in Table 3.

Table 4
Respondent Satisfaction with Their Regular Doctor

1996	1997	1998	1999	2000	2001	2003	2004
96.4%	94.8%	96.2%	96.1%	96.4%	97.0%	96.7%	96.7%

- Ninety-seven percent of respondents said they were very satisfied or satisfied with the services of their regular doctor. This is comparable to prior surveys, as shown in Table 4.

Table 5
Respondent Satisfaction with Reaching Their Regular Doctor Evenings, Nights, Weekends, and Holidays

1999	2000	2001	2003	2004
90.1%	87.2%	88.8%	91.5%	91.7%

- Almost 92 percent of respondents said they were either very satisfied or satisfied with reaching their regular doctor evenings, nights, weekends, and holidays. This percentage is the highest ever reported, as shown in Table 5.
- Almost 82 percent of respondents said they (or their child) saw their doctor the same day when they called for an appointment when sick; 96.5 percent said they were seen either the same day or the next day. In 2001, only 70 percent of respondents reported that they (or their child) saw their doctor the same day when they called for an appointment when sick.
- Some 93 percent of respondents reported that they had seen their regular doctor within the past 12 months – the highest percentage ever reported.

Table 6
Respondent Satisfaction with Getting Specialist Referrals

1996	1997	1998	1999	2000	2001	2003	2004
92.7%	92.0%	93.2%	94.9%	93.8%	94.4%	94.6%	94.6%

- Nearly 95 percent of respondents said they were very satisfied or satisfied with getting a referral to a specialist. These results are comparable to prior years, as shown in Table 6.

Table 7
Respondent Satisfaction with Emergency Room Treatment

1999	2000	2001	2003	2004
84%	79%	82%	86%	86%

- Eighty-six percent of respondents were very satisfied or satisfied with their (or their child's) emergency room treatment, if they used an emergency room (ER). This was the highest level ever reported, as shown in Table 7.

3.6 RItE Care Has Improved Health Outcomes

The following illustrates how effective RItE Care has been in improving health outcomes for enrollees:

- Short interbirth interval (i.e., less than 18 months), which is associated with low birth weight, declined by more than 20 percent for Medicaid mothers from 1993 (pre-RItE Care) to 2003 (RItE Care).²² The gap between women on Medicaid and privately insured women on this measure virtually disappeared by 1999.
- An analysis²³ of infant death in Rhode Island from 1990 to 1999 showed that the rate of preventable infant deaths decreased significantly in families with public coverage:
 - From 1990 to 1999, the infant mortality rate declined 36 percent for infants “with public insurance” – from 10.7 deaths per 1,000 births to 6.8 deaths per 1,000 births
 - The gap between the public insurance infant mortality rate and private insurance infant mortality rate was reduced by over half, from 4.3 points in 1990 to 1.5 points in 1999

²² *Ibid.*

²³ Griffin, J. *Rhode Island Infant Mortality 1990 – 1999: Changes in Causes of Death and Period of Death by Insurance Status*, Medicaid Research and Evaluation Project, March 2002.

- The neonatal mortality (i.e., less than 28 days after birth) for infants with public insurance decreased 23 percent, from 6.2 death per 1,000 births in 1990 to 4.8 deaths per 1,000 births in 1999
- The post neonatal mortality (i.e., 28 days or more after birth) for infants with public insurance decreased more sharply, 57 percent, from 4.5 deaths per 1,000 births in 1990 to 1.9 deaths per 1,000 births in 1999. Postneonatal mortality is considered a measure of access to pediatric care.²⁴
- In a study²⁵ of immunization status of 19- to 35-months-old children who had been continuously enrolled in RIte Care for at least one year, the immunization rates were as follows:
 - The overall immunization rate for having received all indicated doses of Dta/DTP, polio, Hib, MMR, and hepatitis B was 75 percent
 - When hepatitis B was excluded from the assessment, 81 percent of children were up to date for all doses of the remaining four vaccines

These results compare favorably with national and Rhode Island rates as measured in the Centers for Disease Control and Prevention National Immunization Survey (NIS)²⁶ as Table 8 shows.

Table 8

Immunization Coverage Rates for 19- to 35-month-olds as Measured by NIS

Sample	Overall*%	DtaP%	Hib%	Hepatitis B %	MMR %	Polio %
National	76	81	93	84	91	91
Rhode Island	81	89	96	87	95	96
RIte Care	81	87	94	88	91	95

* Overall status includes all vaccines except hepatitis B

- In a study²⁷, 79.8 percent of children aged 19 to 35 months who had been continuously enrolled in RIte Care for at least one year had a documented blood lead screen test. Minority children, children in homes with other than English spoken in the home, and

²⁴ Centers for Disease Control and Prevention. "Postneonatal Mortality Surveillance – US 1980 – 1994," *Morbidity and Mortality Weekly Reporter*, 47 (15), 1998.

²⁵ Vivier, P. M., et.al. "An Analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *The Journal of Pediatrics*, 139(5), November 2001, 624-629.

²⁶ Centers for Disease Control and Prevention. "National, State, and Urban Area Vaccination Coverage Levels among Children 19 – 35 Months – United States, 1997," *Morbidity and Mortality Reporter*, 47, 1997, 547-554.

²⁷ Vivier, P.M., et.al. "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed Care Program," *Pediatrics*, 108(2), 2001.

children living in core cities all had statistically significant higher screening levels. These are important results given the risk factors associated with lead poisoning. Screening levels also varied by primary care site:

- | | |
|-------------------------|--------------|
| ○ Office-based | 67.8 percent |
| ○ Health center | 85.8 percent |
| ○ Hospital-based clinic | 88.6 percent |
| ○ Staff model HMO | 90.9 percent |

These screening rates were dramatically higher than those published in national surveys.²⁸

The screenings found that children enrolled in RItE Care had a higher percentage (at 29.4 percent) with elevated blood lead levels (>10 mg/dl) on at least one test, when compared to national data²⁹ (at 8.6 percent).

The State of Rhode Island recognizes the importance of lead screening in order to identify lead poisoning and intervene early. It is also important to recognize in this regard that DHS supports a Comprehensive Lead Center Program that includes window replacement as a RItE Care covered benefit.

3.7 RItE Care Has Been Budget Neutral

As a condition of receiving the waiver from the Federal Government making RItE Care possible, the RItE Care demonstration must be “budget neutral.” This means that the demonstration cannot cost more than it would have absent the demonstration, within agreed-upon allowances for increases in costs (called “trend factors”).

As Table 9 shows, Rhode Island has operated within these budget neutrality limits across the first ten years of the demonstration. It should be noted that budget neutrality is tested over the entire demonstration period, not in any given year of demonstration. Thus, even though the costs under the waiver exceeded the budget neutrality limit in three of the eleven years under the demonstration to date, overall, the demonstration has been under its budget neutrality limit. Put another way, RItE Care has achieved its goal of containing Medicaid expenditures.

²⁸ Kaufmann, R. B., *et.al.*, “Elevated Blood Lead Levels and Blood Lead Screening among US Children Aged One to Five Years: 1988 – 1994,” *Pediatrics*, 106(6), 2000.

²⁹ *Ibid.*

Table 8

Federal Budget Neutrality Summary for Waiver Years 1 – 11

	Budget Neutrality Limit		Waiver Expenditures		Variance	
	Gross Dollars	Federal Share	Gross Dollars	Federal Share	Gross Dollars	Federal Share
Original Waiver Period						
8/1/94 -7/31/95	\$48,575,213	\$26,954,386	\$37,969,068	\$21,068,157	\$10,606,145	\$5,885,350
8/1/95 – 7/31/96	\$119,285,977	\$64,545,642	\$96,086,854	\$51,993,115	\$23,199,123	\$12,553,045
8/196 – 7/3197	\$121,839,003	\$65,659,039	\$120,307,290	\$64,833,565	\$1,531,713	\$825,440
8/1/97 – 7/31/98	\$125,204,629	\$66,734,067	\$119,616,791	\$63,750,070	\$5,587,838	\$2,978,318
8/1/98 – 7/31/99	\$139,625,464	\$75,272,088	\$129,313,100	\$69,714,601	\$10,312,364	\$5,559,395
Subtotal Original Waiver Period	\$554,530,286	\$299,165,222	\$503,293,103	\$271,359,508	\$51,237,182	\$27,801,548
First Waiver Extension Period						
8/1/99 – 7/31/00	\$170,059,915	\$91,509,240	\$152,082,287	\$81,841,386	\$17,977,628	\$9,673,762
8/1/00 – 731/01	\$175,706,215	\$94,512,373	\$168,548,392	\$90,656,666	\$7,157,823	\$3,850,193
8/1/01 – 7/31/02	\$179,654,337	\$94,623,929	\$174,688,556	\$92,000,473	\$4,965,781	\$2,615,477
Subtotal Waiver Extension Period	\$525,420,467	\$289,645,242	\$495,319,235	\$264,498,525	\$30,101,232	\$16,139,432
Second Waiver Extension Period						
8/1/02 – 7/31/03	\$199,479,803	\$111,549,106	\$203,884,375	\$114,004,206	(\$4,404,572)	(\$2,463,037)
8/1/03 – 7/31/04	\$227,849,104	\$133,565,145	\$233,949,592	\$137,145,242	(\$6,100,488)	(\$3,576,106)
8/1/04 – 7/31/05	\$266,153,287	\$147,235,998	\$280,996,788	\$155,443,033	(\$14,843,500)	(\$8,211,424)
Subtotal Waiver Extension Period	\$693,482,194	\$392,350,249	\$718,830,755	\$406,592,481	(\$25,348,560)	(\$14,250,567)
Cumulative Total	\$1,773,432,947	\$981,160,713	\$1,717,443,093	\$942,450,514	\$55,989,854	\$29,690,413

3.8 Third-Party Liability

Making certain RIte Care is the payer of last resort is of ongoing importance in dealing with the State’s budgetary issues. The Rhode Island General Assembly enacted legislation (Section 40-6-9.1) that enables a data match for DHS to identify and pursue other sources of payment for covered services. The statute applies to “all health insurers, including, but not limited to, health maintenance organizations, third party administrators, nonprofit medical service corporations and nonprofit hospital corporations” that must report information on private coverage for Medicaid eligibles to DHS upon request.

The initial data match was delivered on August 1, 2003, for private health insurance policies

active from April 1, 2002 to April 1, 2003. The total³⁰ Medicaid records matched (i.e., on Social Security Number, date of birth, first five letters of the last name, and first three letters of the first name) with other coverage were 29,157. Of these, 19,239, or 66 percent, represented new information and 1,960, or 7 percent, represented updates to information already in the MMIS. In addition, 7,282, or 25 percent, were already known to the MMIS.

Table 9 shows the third-party liability (TPL) segments identified via the data match for all of Medicaid by quarter during SFY 2005.

Table 10

Third-Party Liability Segments Identified Via Data Match by Quarter in SFY 2005

Quarter	Medical TPL	Pharmacy TPL	Total New/Updated Policies
1 st Quarter 2005	4,500	3,623	16,575
2 nd Quarter 2005	4,658	2,817	11,111
3 rd Quarter 2005	11,390	8,452	3,0359
4 th Quarter 2005	4,760	5,228	13,213
Total	25,308	20,120	71,258

The total cost avoidance due to TPL during SFY 2005 was \$10,040,918. In addition, cost recoveries were \$4,276,144. The total³¹ savings, through a combination of cost avoidance and cost recoveries were \$5,317,062 in SFY 2005.

With the State's evolving experiences gained through these data matches, the State believes that future quarterly data matches will continue to hold great promise in assuring the appropriateness of public payments for health care under both RIt Care and RIt Share (as well as all of Medicaid) and, thus, containing public expenditures.

³⁰ It should be noted that the data match is for all of Medicaid, not just for RIt Care and RIt Share.

³¹ *Ibid.*

IV. RITE SHARE FOR CHILDREN AND FAMILIES

The goal of the RItE Share premium assistance program is to support families in their efforts to obtain or maintain private, employer-sponsored health insurance. Enrollment in RItE Share is mandatory for Medicaid-eligible individuals whose employers offer an approved health plan. Enrollment of both employees and employers in the RItE Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RItE Share. As of July 2005, 1,176 employers were approved for participation in RItE Share, which is an increase from 969 as of July 2004.

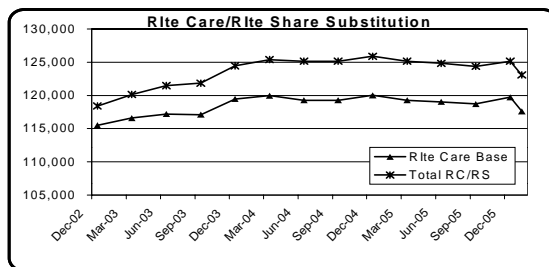
Since the program started, DHS has been transitioning RItE Care members into RItE Share. At the time RItE Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RItE Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RItE Care member to RItE Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance market present additional challenges to RItE Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a \$200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a \$750 deductible could reduce the premium rate by, say, 9 or 10 percent. Thus, while plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a “down economy”.

Figure 5 shows the incremental gains in enrollment in RItE Share through July 31, 2005. There were 5,710 individuals enrolled in RItE Share as of July 31, 2005, with 48 in the process of being enrolled in RItE Share. RItE Share enrollment is down from a year ago when enrollment was 5,982, reflecting partly an increase the costs of ESI that makes it more difficult to surmount RItE Share’s cost-effectiveness test. The figure also shows that RItE Share is having its intended effect of stabilizing RItE Care enrollment, while increasing RItE Share enrollment.

Figure 5

Rite Care/Rite Share Enrollment Update as of January 31, 2006 *



	Rite Care Base	Rite Share Current	Total RC/RS
Qtr ending D-02	115,526	2,905	118,431
Qtr ending M-03	116,640	3,511	120,151
Qtr ending J-03	117,218	4,268	121,486
Qtr ending S-03	117,154	4,701	121,855
Qtr ending D-03	119,479	5,006	124,485
Qtr ending M-04	119,986	5,432	125,418
Qtr ending J-04	119,279	5,899	125,178
Qtr ending S-04	119,294	5,873	125,167
Qtr ending D-04	120,049	5,876	125,925
Qtr ending M-05	119,311	5,884	125,195
Qtr ending J-05	119,049	5,796	124,845
Qtr ending S-05	118,741	5,640	124,381
December-05	119,782	5,435	125,197
January-06	117,654	5,465	123,119

Net Change This Month **(2,108)** **30** **(2,078)**

* Includes Rite Care base population and foster children; does not include children with special health care needs.

Rite Share makes ESI coverage affordable for many families while saving the State money; Rite Share pays all or part of the employee's share of coverage and the employer pays their share. The State will continue to transition Medicaid-eligible families who have access to ESI into Rite Share in an effort to contain the growth in the cost of health insurance for Medicaid eligibles while simultaneously addressing the level of uninsurance in the State.

4.1 Rite Share Has Saved Money

Table 11 shows Rite Share estimated savings for SFY 2002, SFY 2003, SFY 2004, and SFY 2005 through February 28, 2005, as well as projected savings for SFY 2005.³² As the table

³² Rhode Island Department of Human Services. *Rhode Island's Rite Share Program: Estimated Savings State Fiscal Year 2005*, January 2006.

shows, both gross and net RIt Share savings have been increasing over time. There have been aggregate Gross RIt Share Savings of \$12,250,449 since RIt Share began, through February 2005. It is expected that aggregate Gross RIt Share Savings will exceed \$14 million by the time SFY 2005 expenditures are complete. Aggregate Net RIt Share Savings, through February 2005, have been \$2,612,931. It is expected that that aggregate Net RIt Share Savings will exceed \$3 million by the time SFY 2005 expenditures are complete.

Table 11

RIt Share Gross and Net Savings

	SFY 2002	SFY2003	SFY 2004	SFY 2005 through 2-28-05 (8 months)	SFY 2005 Projected
(1) RIt Care Capitation	\$781,998	\$5,266,585	\$9,581,775	\$7,913,693	\$11,870,540
(2) Risk Share	\$38,993	\$293,811	\$898,312	\$562,103	\$843,155
(3) Stop-Loss	\$5,546	\$21,472	\$102,699	\$74,640	\$111,960
(4) CHC Transition Payments	\$19,487	\$143,148	\$256,143	\$262,161	\$393,242
(5) Subtotal (1+2+3+4)	\$846,024	\$5,725,016	\$10,838,929	\$8,812,597	\$13,218,896
(6) Cost-Share Paid	\$ 0	\$199,845	\$318,148	\$238,258	\$357,387
Total RIt Care Benefit Expenditures Avoided (5-6)	\$846,024	\$5,525,171	\$10,520,781	\$8,574,339	\$12,861,509
RITE SHARE EXPENDITURES					
(1) Premium Subsidies	\$406,453	\$2,366,504	\$4,641,058	\$3,578,139	\$5,367,209
(2) Supplementary Benefits	\$14,870	\$340,048	\$1,055,245	\$813,549	\$1,220,324
Total RIt Share Benefit Expenditures	\$421,323	\$2,706,552	\$5,696,303	\$4,391,688	\$6,587,532
RITE SHARE SAVINGS					
(1) Federal-Level Savings	\$260,711	\$1,780,426	\$3,136,886	\$2,675,694	\$ 4,013,541
(2) State-Level Savings	\$163,990	\$1,038,193	\$1,687,592	\$1,506,957	\$2,260,436
(3) RIt Share Benefit Savings (RC Expenditures Avoided minus RIt Share Expenditures)	\$424,701	\$2,818,619	\$4,824,478	\$4,182,651	\$ 6,273,977
(4) State-Funded RIt Share Administrative Expenses	\$332,270	\$507,796	\$538,968	\$404,767	\$607,151
(5) Total (State and Federal- Funded) RIt Share Administrative Expenses	\$664,540	\$1,015,592	\$1,077,936	\$809,534	\$1,214,301
(6) State-Level RIt Share Savings, net of RS admin costs (2-4)	\$(168,280)	\$530,397	\$1,148,624	\$1,102,190	\$1,653,285
(7) Public (State and Federal) RIt Share Savings, net of RS admin costs (3-5)	\$(239,839)	\$ 1,803,027	\$ 3,746,542	\$ 3,373,117	\$ 5,059,676

4.2 Challenges Facing RItE Share

Several circumstances make it challenging for RItE Share to realize its full potential for enrollment:

- Employers are not required to submit information about their health insurance benefits to the Department of Human Services, making it difficult to transition RItE Care members to RItE Share.
- Federal ERISA laws pre-empt any State law that would require employers to enroll RItE Share eligible families in the employer-sponsored health insurance outside of open enrollment periods.
- Federal Medicaid rules mandate different levels of benefits for family members (children, adults, and pregnant women) making it complex for RItE Share to wrap-around varying benefit levels within a family.
- Increases in premiums are being passed on to employees, making it more difficult to meet cost-effectiveness tests for Federal financial participation (FFP).
- Employers are adopting health plans with increased member cost-sharing (e.g., high deductibles) and scaled-down benefits that make it harder to “wrap around” Medicaid.
- Health Savings Accounts (HSAs) and other flexible benefit programs make it more difficult to mandate that employees take up coverage.

V. COST-SHARING FOR CHILDREN AND FAMILIES

The RItE Care Stabilization Act of 2000 mandated cost-sharing for RItE Care and RItE Share families with family income above 150 percent of the FPL (\$22,890 for a family of three). Since January 1, 2002, all families in RItE Care or RItE Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., \$24,135 for a family of three as of January 1, 2005). In November 2001, families received two letters and an official notice about the change. The first monthly bills were sent in December 2001, requiring payment by January 1, 2002. As of August 1, 2002, State law mandated that cost-sharing be raised to approximately five percent of the FPL. This amount ranges from about \$61 to \$92 per month. Rhode Island was one of four States increasing enrollee cost-sharing in 2002, with another 11 States were expected to do so in 2003³³.

Monthly premiums are collected in two ways:

- For RItE Care, DHS sends a bill and the family pays DHS directly by mailing a check
- For RItE Share, DHS deducts the monthly premium from the amount it reimburses the member for the employee's share of employer coverage

On a monthly basis, about 10 percent of all RItE Care/RItE Share families are subject to cost-sharing. Table 12 shows the number of families and individuals, by income level, active in cost-sharing as of July 2005. There were 5,383 families (13,327 individuals) active in cost-sharing at the end of July 2005, compared to 5,143 families (12,913 individuals) at the end of July 2004. There were 19,517 families *ever* active in cost-sharing through July 2005, compared to 15,557 families ever active in cost-sharing through the end of July 2004.

Table 12

Families and Individuals Active in Cost-Sharing as of July 2005

Income Level	Families	Adults	Children	Total Individuals
150-185% of FPL	3,382	4,232	5,643	9,875
185-200% of FPL	722	61	1,213	1,274
200-250% of FPL	1,279	71	2,107	2,178
Total	5,383	4,364	8,963	13,327

Most families make their cost-sharing payments on time. However, sanctions (i.e., disenrollment

³³ Academy Health. *State of the State: Bridging the Health Coverage Gap*, January 2003.

for non-payment of premiums) are applied when a family does not pay the required cost-sharing for two months. The sanction extends for four months. If the family meets eligibility criteria, the family may re-apply and return to coverage at the end of the four months. If at any time during the four months the family's income falls below 150 percent of the FPL, the family may re-apply and be found eligible for coverage. From January 2002 to September 2005, pregnant women and infants under one were not disenrolled for non-payment of cost-sharing but continued to incur a cost-sharing liability if their income was above 185 percent of the FPL. Beginning in October 2005, pregnant women and infants under age one are exempt from paying monthly RItE Care premiums, as a result of legislation passed by the General Assembly in June 2005. Table 13 shows the sanctions applied in SFYs 2002, 2003, 2004 and 2005. As the table shows, 3,387 individuals were disenrolled for non-payment of cost-sharing in SFY 2005, which is down from 3,675 in SFY 2003 and a high of 4,707 in SFY 2003.

Table 13

Families and Individuals Disenrolled for Non-Payment of Cost-Sharing

State Fiscal Year	Families	Adults	Children	Total Individuals
2005	1,608	871	2,516	3,387
2004	1,653	1,047	2,628	3,675
2003	1,969	1,441	3,266	4,707
2002	1,037	743	1,658	2,401

A May 2003 analysis of 1,853 families who were first *sanctioned* (i.e., terminated from participation in RItE Care for non-payment of premiums) in Calendar Year 2002 showed that 1,101, or 59 percent, of these families returned to RItE Care coverage. Another 82 families, or 4 percent, met other Medical Assistance criteria that allowed specific family members to continue coverage. The remainder of the families, 670, or 36 percent, had not returned to coverage by the time of the analysis.

VI. RITE CARE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Enrollment of children with special health care needs into RItE Care began in November 2000 with the enrollment of children in foster care (substitute placement). Because NHPRI was the only Health Plan participating in RItE Care willing to enroll this population, children foster care are enrolled on a voluntary basis.³⁴ As of June 30, 2005, there were 2,200 children in foster care enrolled in RItE Care (or 90 percent of these children eligible to be enrolled in RItE Care).

On January 29, 2003, the State was notified by the Centers for Medicare & Medicaid Services (CMS) that its RItE Care waiver amendment request to enroll children with special health care needs on a mandatory basis (excluding children in foster care who were already enrolled) into RItE Care Health Plans had been approved. Prior to this waiver amendment, children with special health care needs had been served through the Medicaid fee-for-service system, which tends to be fragmented, to have limited choice and access³⁵, and to have multiple systems of care.

Children with special health care needs covered under the waiver include the following groups of Medicaid-eligible children up to age 21:

- Blind/disabled children and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)
- Children eligible under Section 1902(e)(3) of the Social Security Act (“Katie Beckett” children)
- Children receiving subsidized adoption assistance

At the time of the submission of the request for this waiver amendment, the State estimated that there were approximately 8,800 children who would be affected by it.

In pursuing this waiver amendment, the State did so to build upon its successes with RItE Care and to extend what it had learned to design and implement a service delivery strategy for children with special health care needs. Specifically, the State sought to increase accountability, provide focused oversight and monitoring, improve cost-effectiveness of health coverage, and integrate family coverage for these populations of Medicaid-eligible children. The State believes that these children can benefit from improved access to and coordination of care afforded

³⁴ Federal regulations require that at least two health plans be available in order to enroll any given population on a mandatory basis.

³⁵ For example, under Medicaid fee-for-service less than 40 percent of practicing physicians in the State participate. Under RItE Care, more than 90 percent of the practicing physicians participate.

through RItE Care, using a service delivery strategy that focuses on the child's unique needs, the strength of the family, and coordination of services. Slowing the rate of increases in costs is anticipated by-product of improved care.

The State provided significant opportunity for public input in the development of this waiver amendment, including:

- **Stakeholder meetings** – Thirteen stakeholder meetings were scheduled over a four-month period that began on March 25, 2002. The initial meeting was attended by approximately 125 individuals.
- **Additional stakeholder input** – Additional informational meetings were held with advocacy groups, providers, State agencies, and RItE Care participating Health Plans.
- **Other stakeholder communication** – The DHS Web site was updated to include information on the proposed Waiver amendment. Letters and fact sheets were mailed to parents, guardians, and adult caretakers of the targeted children.

Notices of public meetings were published in *The Providence Journal*.

As indicated above, the State's waiver approval was to enroll all eligible children with special health care needs on a mandatory basis in RItE Care-participating Health Plans. Because only NHPRI agreed to enroll these children, these children are being enrolled into NHPRI on a voluntary basis.³⁶ A policy decision was made to phase in enrollment, beginning in September 2003. The phase-in was considered important to allow DHS (and its contractors) to work with the affected families to make certain each child's health care needs were known in order to assure continuity of care and to educate families how to access care within a managed care environment.

At the time that this voluntary enrollment was scheduled to begin, there were 8,799 children on Medical Assistance in the three categories above. Of these children, 5,006 were deemed eligible to enroll in managed care (e.g., were not covered under another waiver, did not have other insurance coverage, or were not too old). As of June 30, 2005, 4,001 children with special health care needs had enrolled in NHPRI compared to 3,540 enrolled as of June 30, 2004. This is estimated to be approximately 80 percent of those eligible to be enrolled (e.g., not participating in another waiver or have third-party coverage). Table 14 shows a breakdown of those children with special health care needs not enrolled in NHPRI as of June 30, 2005 and the reasons why they are not enrolled:

³⁶ BlueCHiP and United Healthcare of New England declined to enroll these children. Federal regulations require that at least two plans be available in order to enroll a population on a mandatory basis.

Table 14

Children with Special Health Care Needs Not Enrolled in NHPRI as of June 30, 2005, by Reason

Reason Not Enrolled in NHPRI	Population Group			
	Children on SSI	Katie Beckett Children	Adoption Subsidy	Total
Should Be in Review Queue	539	180	223	942
Excluded for TPL	385	800	763	1,948
In Long-Term Care	13			13
In MR/DD Waiver	91	1	4	96
Located Out-of-State	32		75	107
Excluded for Clinical Reasons	44	48	9	101
Other*	1,377	131	267	1,775
Pending Review	239	95	92	426
Total	2,720	1,255	1,433	5,408

*Principally those who do not want to enroll in a Health Plan

APPENDIX A

*The Impact of Rite Care on the Health of Pregnant Women
and Their Newborns, 1993-2003*

ATTACHMENT B

Profiles and Trends of the Uninsured in Rhode Island: 2004 Update

APPENDIX C

***Characteristics of Uninsured Rhode Islanders in Three Age
Groups***

APPENDIX D

*Premium Assistance Programs: How Are They
Financed And Do States Save Money?*



The Impact of Rlte Care on the Health of Pregnant Women and their Newborns

1993 - 2003

New Analyses:

Racial Disparities
Life Stress/Social Support

July 2005



Prepared by Jane Griffin, MPH
RI Medicaid Research and Evaluation Project

The Impact of RItE Care on Adequacy of Prenatal Care and The Health of Newborns – 2003 Update

Table of Contents

	<u>Page</u>
Background/Methods	5
Changes in Distribution of Medicaid Births	7
Demographic Trends by Insurance Status	9
Access to Prenatal Care	11
Adequacy of Prenatal Care	13
Maternal Health Status	15
Newborn Health Status	19
Teen Births	21
Life Stress/Social Support	25

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or call 462-6330

List of Tables

	<u>Page</u>
Table 1: Number of RI Births by Insurance Status and by Age	8
Table 2: Percent of Rhode Island Pregnant/Postpartum Women Who Experience Life Stress by Insurance Coverage - 2003	26
Table 3: Percent of Rhode Island new Mothers who are Unable to Get Different Types of Social Support by Insurance Coverage	27

List of Figures

Figure 1: Percent of Births to Immigrant Mothers	9
Figure 2: Race/Ethnicity of Pregnant Women on Medicaid	10
Figure 3: Percent of Women who Began Prenatal Care In First Trimester by Insurance Status	12
Figure 3a: Percent of Pregnant Women on Medicaid who Began Prenatal Care in First Trimester by Race	12
Figure 4: Percent of Women who Received Adequate/Adequate+ Prenatal Care by Insurance Status	14
Figure 4a: Percent of Pregnant Woman on Medicaid who Received Adequate/Adequate+ Prenatal Care by Race	14
Figure 5: Percent of Pregnant Women who Smoke Cigarettes by Insurance Status	16
Figure 5a: Percent of Pregnant Women on Medicaid who Smoke Cigarettes By Race	16
Figure 6: Percent of Women with Short Interbirth Interval (<18 months) by Insurance Status	18

List of Figures

	<u>Page</u>
Figure 6a: Percent of Women with Short Interbirth Interval on Medicaid (<18 months) by Race	18
Figure 7: Percent Low Birthweight by Insurance Status	20
Figure 7a: Percent Low Birthweight for Medicaid Births by Race	20
Figure 8: Percent of Births to Teenagers (<20 Years Old) by Insurance Status	22
Figure 8a: Percent of Births to Teenagers (<20 Years Old) on Medicaid By Race	22
Figure 9: Percent of Teen Mothers with Previous Live Births by Insurance Status	24
Figure 9a: Percent of Teen Mothers on Medicaid with Previous Live Births by Race	24

List of Appendices

Appendix 1: Maternal and Child Health Indicators by Race for Medicaid Births 1993-2003	28
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The Impact of RItE Care on Adequacy of Prenatal Care and the Health of Newborns – 2003 Update

Background/Methods

The Rhode Island Medicaid Research and Evaluation Project produces an annual health indicators report that tracks the program's impact on prenatal care and newborn health.¹

The Project has used the vital statistics birth file data from 1993 – 2003 (representing 136,996 births) to analyze prenatal care utilization and birth outcome measures. Data from birth certificates is used to monitor several maternal and child health outcome measures and to determine the effect of RItE Care on access and adequacy of prenatal care. This report describes and updates maternal and child health indicators and trends in the following five areas:

- **Demographic Trends** – Immigrant and Hispanic births, age, race, marital status and education by insurance status
- **Access and adequacy of prenatal care** – month of entry into prenatal care, and adequacy of prenatal care
- **Maternal health status** – maternal smoking and interbirth interval
- **Newborn health status** – percent of low birthweight
- **Teen births** – percent of total births and repeat births by insurance status for teen births < 20 years old

¹ Griffin J, RI Medicaid Research and Evaluation Project, The Impact of RItE Care on Adequacy of Prenatal Care and the Health of Newborns, 1997-2002.

In addition this year for all Medicaid births, all the maternal and child health trend indicators will be stratified by race. This analysis shows which groups have contributed the most to improvements in maternal and child health for pregnant women on Medicaid.

In this report there is also a section on measures of life stress for pregnant women living in Rhode Island by insurance coverage. The data on life stress and social support comes from a special analysis of the Pregnancy Risk Assessment Monitoring System (PRAMS) at the RI Department of Health.

Changes in Distribution of Medicaid Births 1993 - 2003

Table 1 shows the annual number of Rhode Island (RI) resident births by Insurance coverage and age. In 2003 4,700 of the RI Births were to women enrolled in Medicaid. This represents 37% of RI births. There were 1,077 births to teen mothers in 2003 and 73% of these teen mothers were on Medicaid.

Table 1
Number of RI Births 1993-2003
By Insurance* and by Age

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Total RI Resident Births	13,565	13,078	12,422	12,300	12,076	12,201	11,958	12,065	12,200	12,441	12,690
Medicaid Births	4,598	4,305	3,510	3,971	3,619	3,618	3,554	4,271	4,533	4,543	4,700
% of Total Births	33.9	32.9	28.3	32.3	30.0	29.6	29.7	35.4	37.2	36.5	37.0
Total Teen Births < 20 yrs	1,444	1,409	1,267	1,299	1,322	1,312	1,211	1,255	1,229	1,160	1,077
Medicaid Teen Births	1,065	987	721	790	718	713	683	839	870	803	781
% of Total Teen Births	73.7	70.1	56.9	60.8	54.3	54.3	56.4	66.8	70.8	69.2	72.5
Medicaid Births by Race											
White	2,410	2,250	1,961	2,248	1,949	1,866	1,781	1,912	2,040	2,023	2,010
Black	698	629	403	491	396	438	420	609	648	626	681
Hispanic	1,168	1,134	882	994	1,050	1,083	1,099	1,479	1,560	1,565	1,698
Asian	322	262	215	237	223	230	248	268	285	328	310

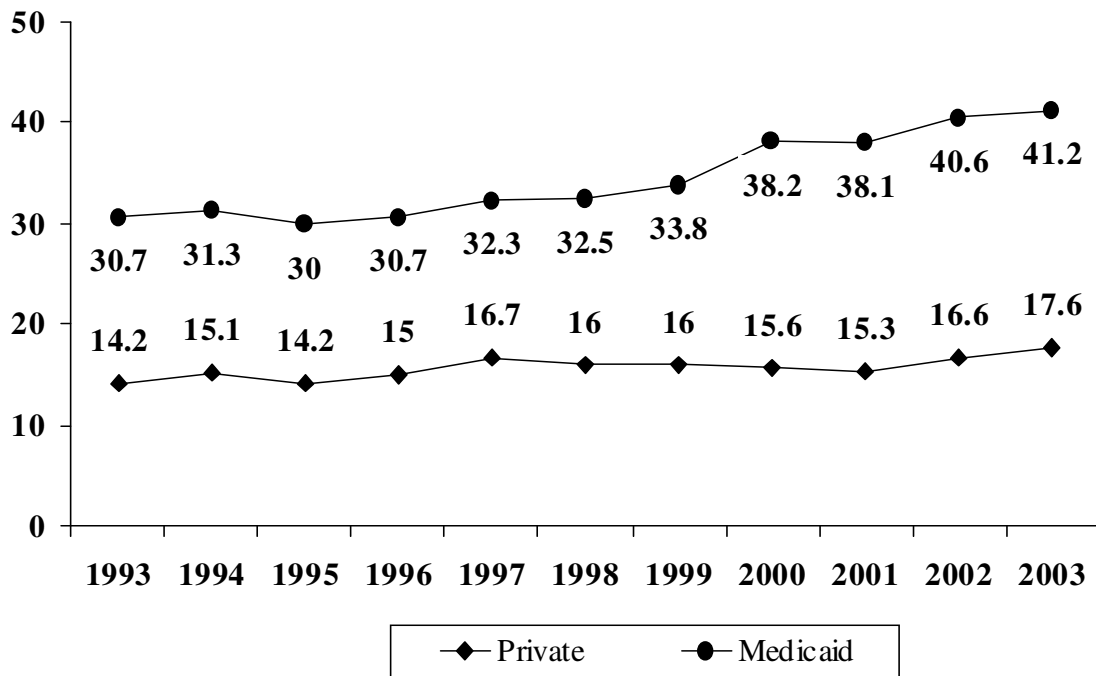
* Insurance – self reported by mother at delivery

Demographic Trends

Immigrant Mothers

Women on Medicaid births are two-and-one-half times more likely to be immigrant mothers. The number of immigrant mothers on Medicaid has increased from 1,219 in 1996 to 1,936 in 2003. Figure 5 shows that in 1993 30.7% of Medicaid births were to immigrant mothers and that proportion has increased to 41.2% in 2003.

Figure 1
Percent of Births to Immigrant Mothers
by Insurance Status 1993-2003

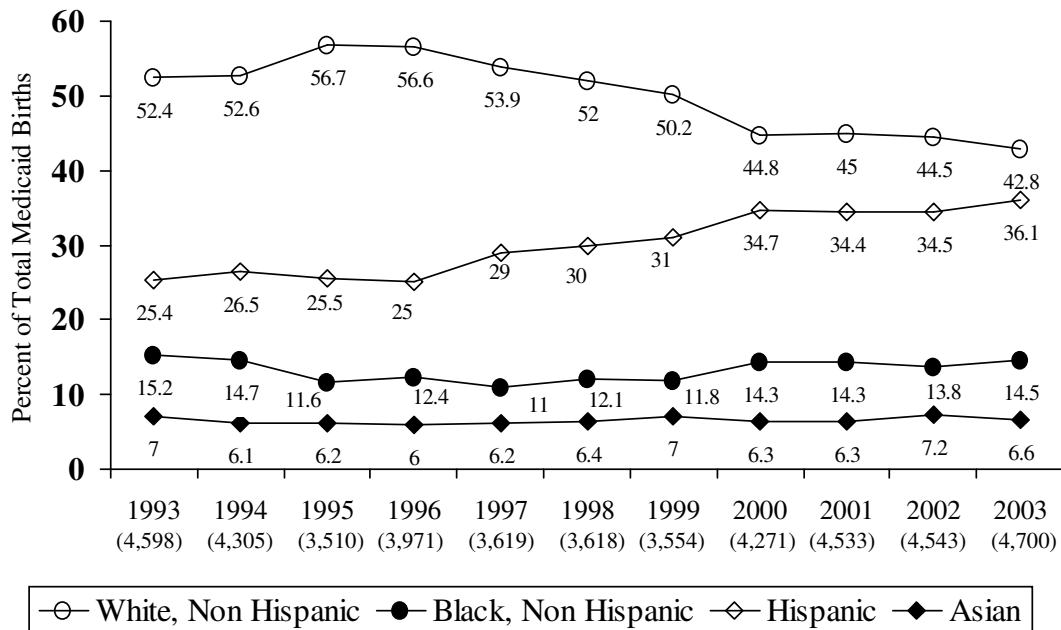


Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Changes in Race/Ethnicity of Pregnant Women on Medicaid

Figure 2 shows the changes in the race/ethnic distribution of pregnant women on Medicaid from 1993-2003. The proportion of Black and Asian births have remained the same at 6.5% and 12% respectively. However, the proportion of white mothers on Medicaid has declined significantly from 52.4% in 1993 to 42.8% in 2003 and the proportion of Hispanic mothers on Medicaid has increased significantly from 25.4% in 1993 to 36.1% in 2003. Over one in three Medicaid births are to Hispanic mothers. (See Appendix 1 for an analysis of all health measures by race of mother.)

Figure 2
Race/Ethnicity Distribution of Pregnant Women on Medicaid



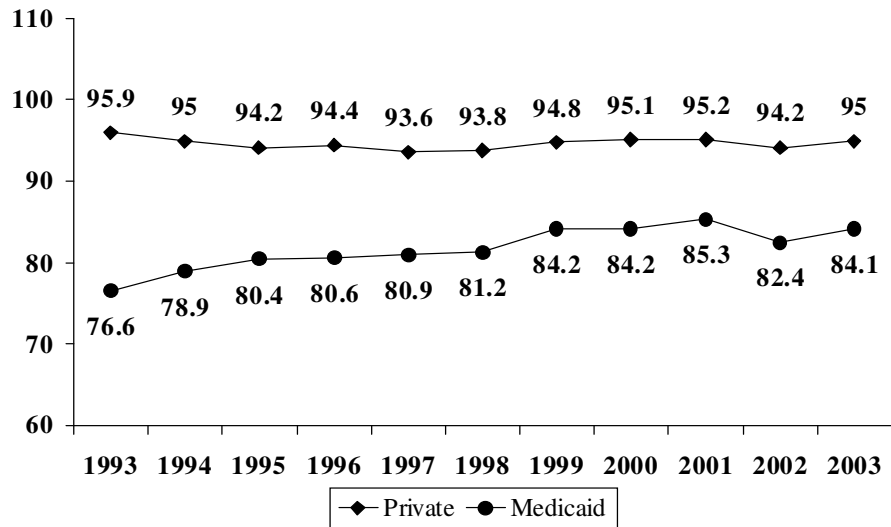
Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Access to Prenatal Care

As Figure 3 shows access to prenatal care for pregnant women on Medicaid, measured by the proportion of women who begin care in the first trimester rose again in 2003 after a small decline in 2002. Improvements in entry to care have consistently improved for pregnant women on Medicaid, whereas the proportion of pregnant women on private insurance entering care in the first trimester has remained the same at 95%.

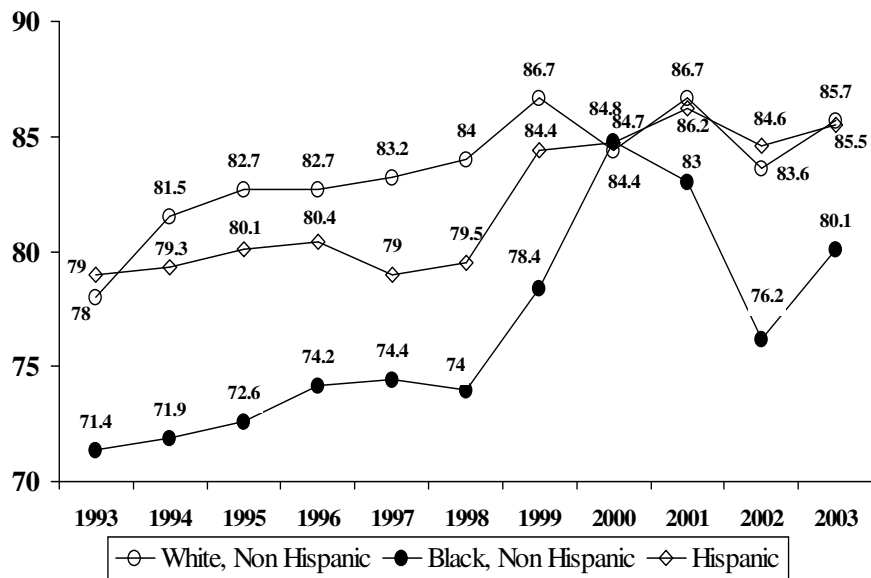
Figure 3a shows that Black women on Medicaid contributed the most to the decline in early entry in 2002. Only 76.2% of black women started prenatal care in the first trimester in 2002. Black pregnant women on Medicaid have consistently had lower rates of early entry into prenatal care compared to Hispanic and white mothers. Hispanic mothers have closed the gap and their rate of access to prenatal care has been the same as white mothers since 2000.

Figure 3
Percent of Women who Began Prenatal Care in First Trimester by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Figure 3a
Percent of Pregnant Women on Medicaid Who Began Prenatal Care in First Trimester By Race



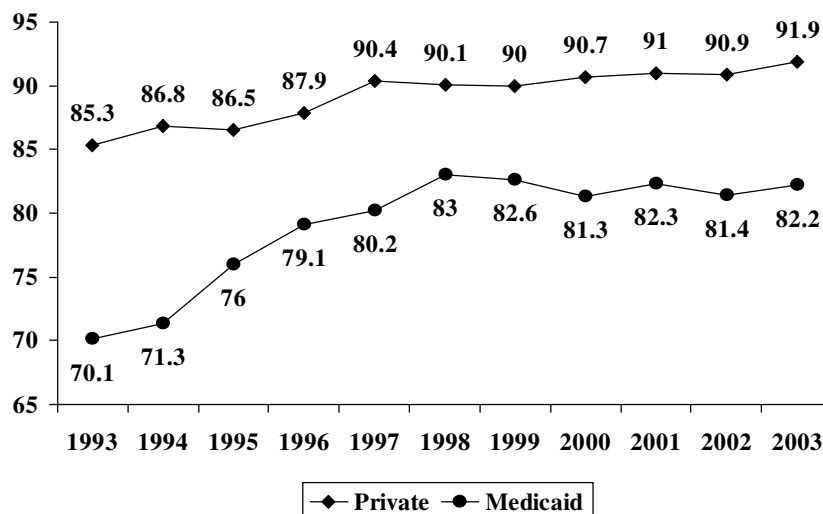
Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Adequacy of Prenatal Care

“Adequate prenatal care” is defined as beginning prenatal care by the fourth month of pregnancy and completing at least 80% of the recommended prenatal visits. Figure 4 shows that in 2003 there was a slight improvement in this health indicator for both pregnant women on Medicaid and privately insured women. Women on Medicaid still have lower rates of adequate prenatal care than women on private insurance. There was a significant increase in adequacy from 1993 to 1998 for both insurance groups and it has remained flat since 1998 for both groups.

Figure 4a shows changes in adequacy of prenatal care for women on Medicaid stratified by race. Improvement in adequate care was seen in all race groups. White pregnant women have consistently received better prenatal care than minority races. On average there is a 10% gap in prenatal care adequacy between white and non-white mothers on Medicaid.

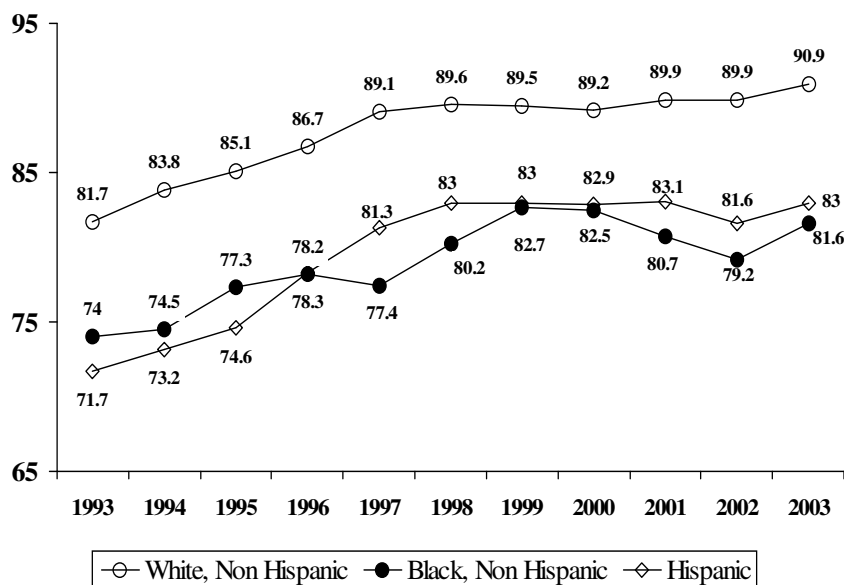
Figure 4
Percent of Women who Received Adequate/Adequate+ Prenatal Care by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project, Vital Statistics Birth File 1993-2003 – (n=136,996)

Note: Adequacy of Care Index was recalculated due to misclassification of some women beginning care after their first trimester so results shown here are different from previous reports

Figure 4a
Percent of Pregnant Women on Medicaid with Adequate Prenatal Care by Race



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Maternal Health Status

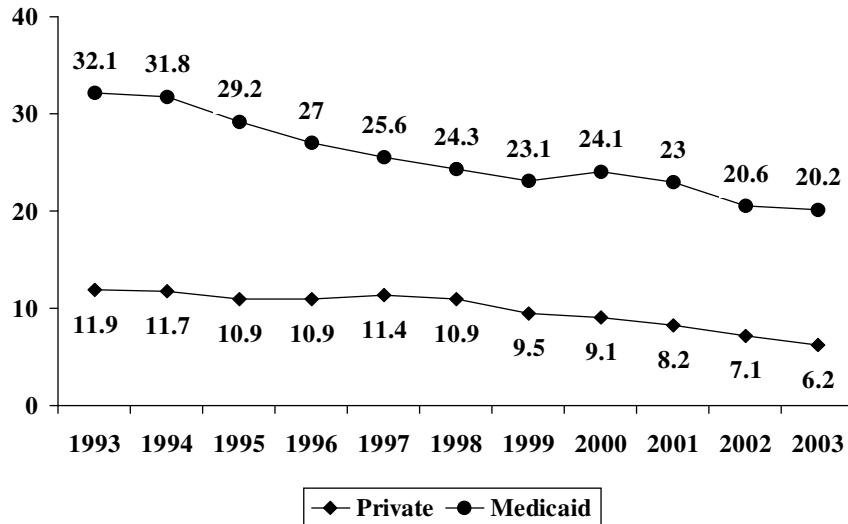
The two principal maternal health status measures collected on the birth certificate are smoking during pregnancy and interbirth interval. Both of these health indicators are major determinants of low birthweight.

Smoking During Pregnancy

Figure 5 shows that smoking rates have decreased significantly for women on Medicaid from 32.1% in 1993, to 20.2% in 2003. The smoking rate for pregnant women on Medicaid has consistently been about three times higher than for women on private .

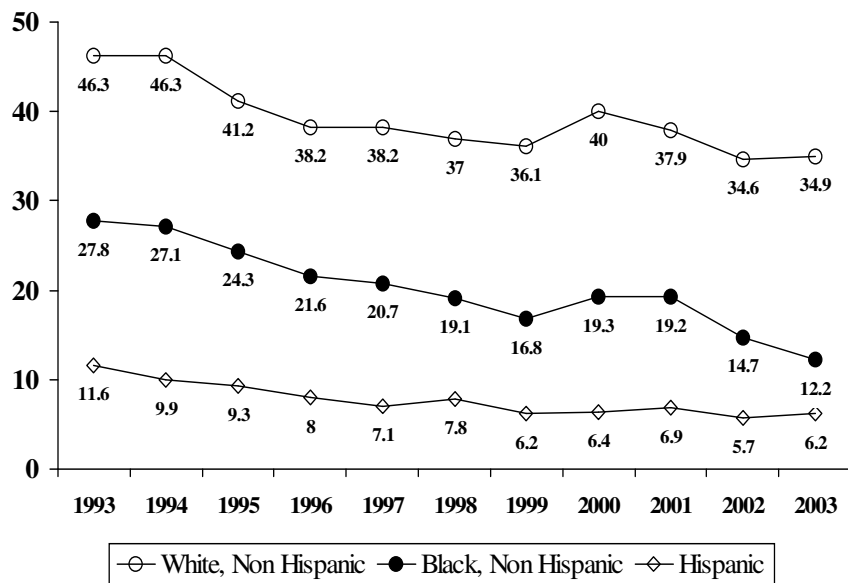
Figure 5a shows that smoking rates differ significantly by race for pregnant women on Medicaid . White mothers have consistently had the highest rate of cigarette smoking. In 1993 almost half of white mothers smoke and in 2003 over one in three smoke. Black mothers have contributed the most to the decline in smoking. In 1993 27.8% of Black mothers smoked and this rate dropped 56% to 12.2% in 2003. Hispanic mothers have the lowest maternal smoking rate at 6%.

Figure 5
Percent of Pregnant Women who Smoke Cigarettes*
by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)
* Self Report

Figure 5a
Percent of Pregnant Women on Medicaid
Who Smoke Cigarettes By Race



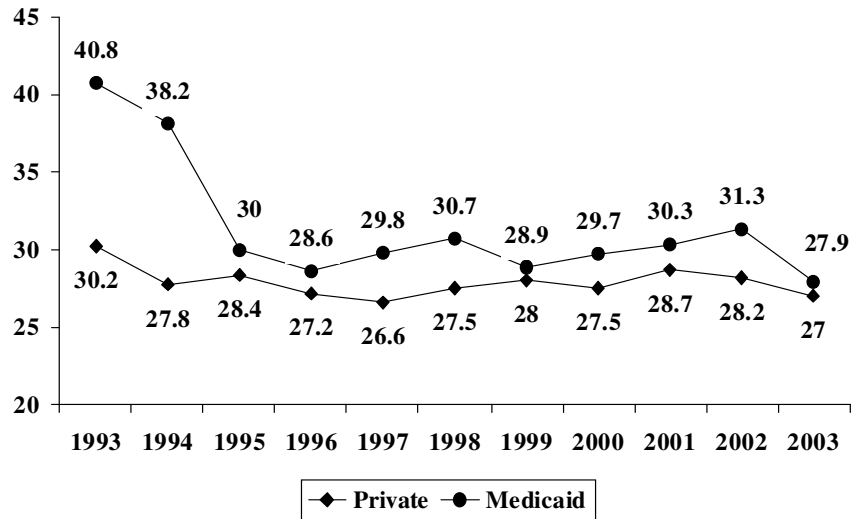
Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Interbirth Interval

A woman who conceives a pregnancy within 18 months of a live birth is considered to have a “Short Interbirth Interval.” Women who have a short interbirth interval are more likely to have a low birthweight baby. The percent of women on Medicaid with a short interval between births has decreased from 41% in 1993 to 27.9% in 2003.

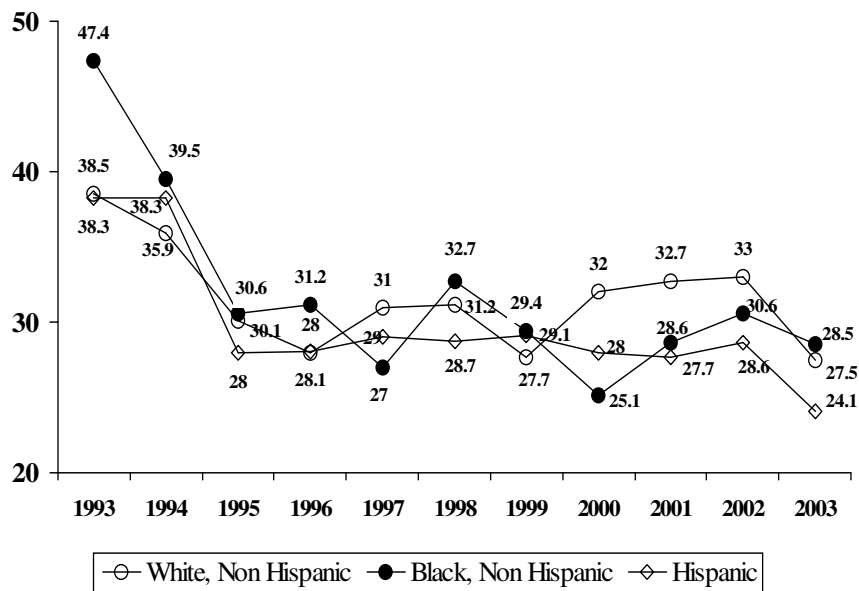
Figure 6 shows that this measure has remained virtually the same between mothers on Medicaid and mothers on private insurance for the past ten years. Figure 6a shows that Blacks contributed the most to the initial decline in interbirth interval from 1993-1995. In 1993 almost one-half (47.4%) of Black mothers waited less than 18 months between pregnancies and in 2003 that proportion was reduced to 28.5%.

Figure 6
Percent of Women with Short Interbirth Interval (<18 months)
by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Figure 6a
Percent of Medicaid Births with Short Interbirth Interval by Race



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

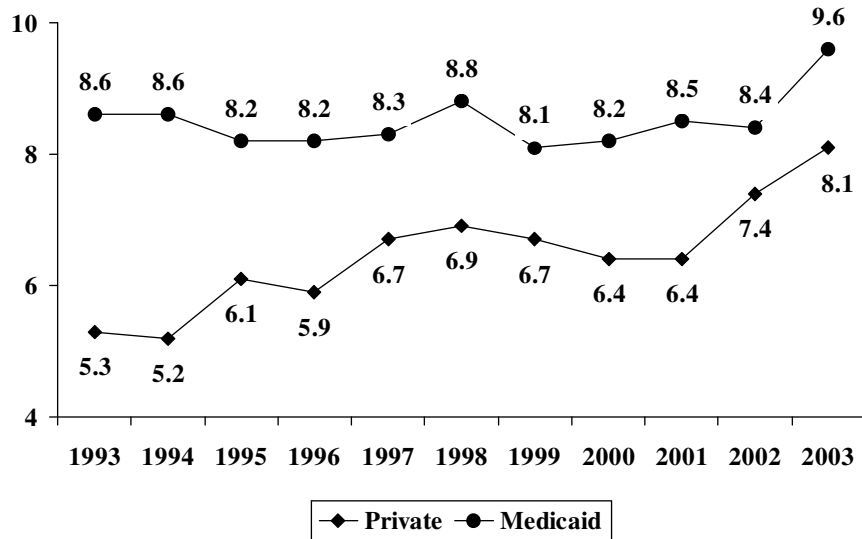
Newborn Health Status

Low Birthweight

Figure 7 shows that in 2003 there was an increase in the proportion of low birthweight numbers on Medicaid. In 1993, the low birthweight rate for Medicaid newborns was 8.6%; in 2003 this rate rose to 9.6%. The low birthweight rate for newborns whose mothers were privately insured also rose from 7.4% to 8.1% during this time period. From 1993 to 2002 the private insurance low birthweight rate has made a steady increase from 5.3% to 8.1%. This is a 53% increase in low birthweight. This increase is primarily due to an increase in multiple births due to fertility drugs.

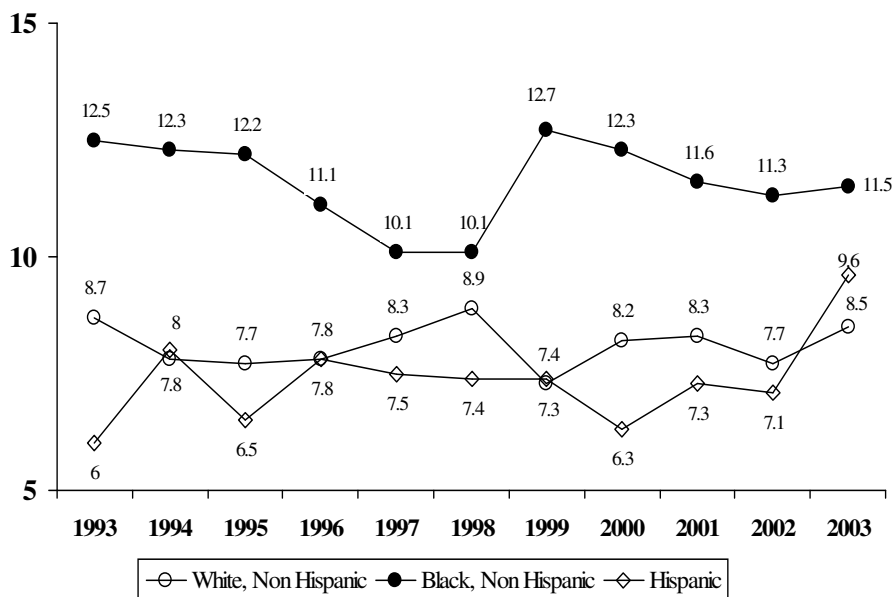
Figure 7a shows that Hispanic mothers on Medicaid contributed the most to the rise in low birthweight in 2003. In 2002 only 7.1% of Hispanic newborns were low birthweight and in 2003 this percent rose to 9.6%. The rate of low birthweight for Black infants has consistently been above White and Hispanic infants.

Figure 7
Percent Low Birthweight
by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

Figure 7a
Percent Low Birthweight for Medicaid Births By Race



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=136,996)

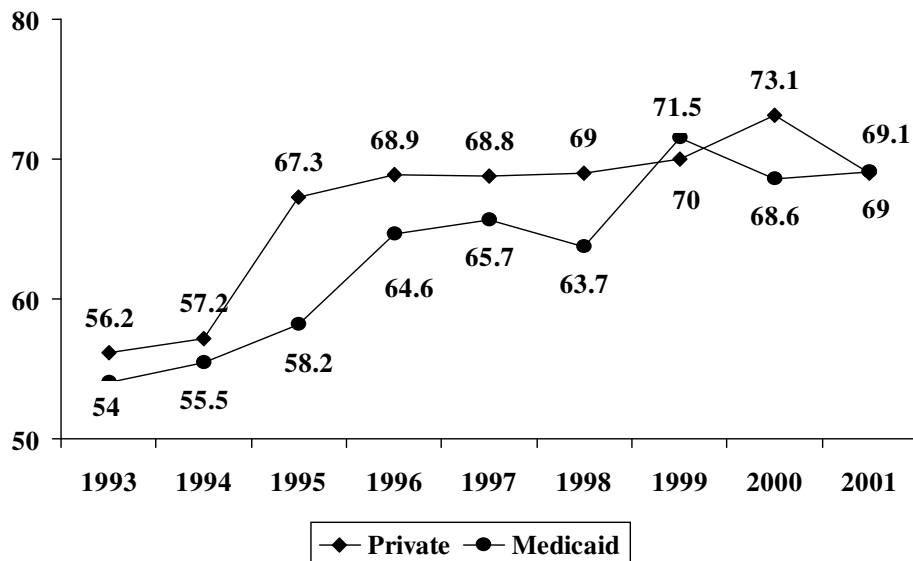
Teen Births

Medicaid provides prenatal, delivery and newborn care for 73% of Rhode Island teen births (see Table 1). Medicaid births to teens have decreased from 23.2% in 1993 to 16.6% in 2003. In 1993 1,065 of the 4,598 Medicaid births were to teen mothers whereas in 2002 the number of teen births dropped to 781 of the 4,700 Medicaid births.

Although Figure 8 shows that the gap is closing between private and Medicaid births, the Medicaid teen birth rate is still five times higher than privately insured.

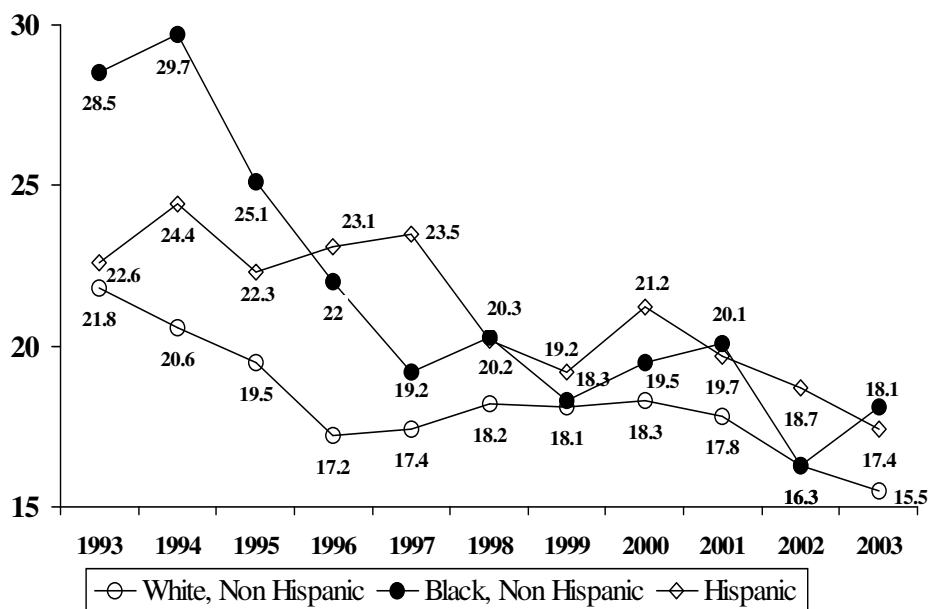
Figure 8a shows the significant decline in teen births by race. The greatest decline in teen births was seen for Black mothers. In 1993 28.5% of births to mothers in Medicaid were to teens and by 2003 this proportion had dropped to 18.1%.

Figure 8
Percent of Pregnant Teenagers who Received
Adequate/Adequate+ Prenatal
by Insurance Status 1993-2001



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2001 – (n=11,748)

Figure 8a
Percent of Births to Teenagers on Medicaid By Race



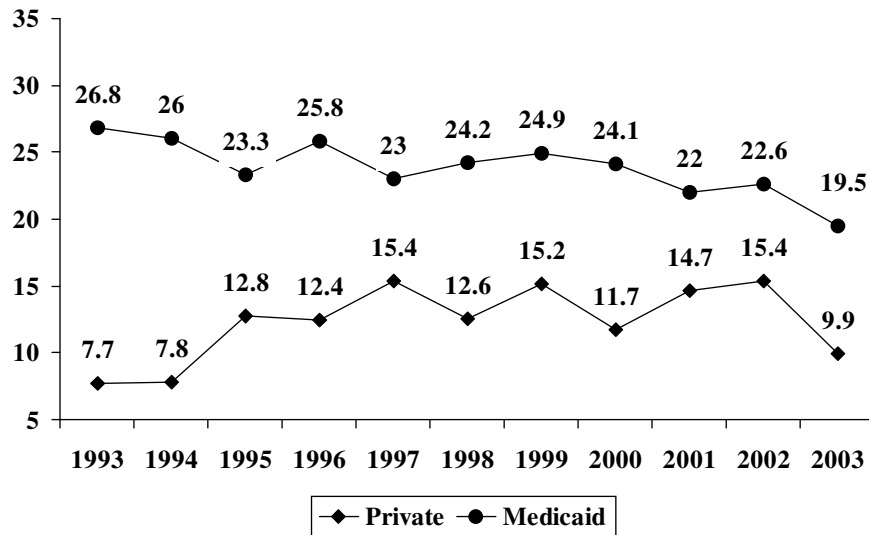
Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=13,985)

Repeat Teen Births

Figure 9 shows that in 2003 approximately one in five birth to teens on Medicaid was to a young woman who was already a mother (19.5%). This rate has made a steady decline in the past five years. Measuring repeat pregnancies is an important indicator to track to see if pregnancy prevention programs are effective.

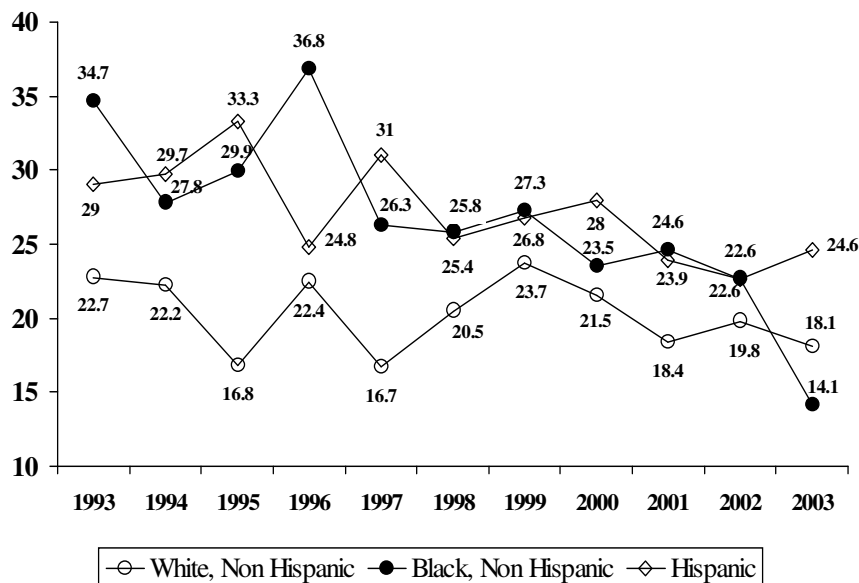
Figure 9a shows that repeat teen births has declined significantly for Black teen mothers on Medicaid. In 1993 they had the highest repeat birth rate at 34.7% and in 2003 they had the lowest at 14.1%. The proportion of second time births or higher for Hispanic and White teens did not decline significantly.

Figure 9
Percent of Teen Mothers with Previous Live Births
by Insurance Status 1993-2003



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=13,985)

Figure 9a
Percent of Teen Mothers on Medicaid With Previous Live Births By Race



Data Source: Medicaid Research & Evaluation Project
Vital Statistics Birth File 1993-2003 – (n=13,985)

Life Stress/Social Support

Pregnant women on RIte Care have significantly higher levels of stress in their lives compared to pregnant women on private insurance. Table 2 shows that women on RIte Care score higher than women on private insurance on all measures of life stress. Their pregnancies are much more likely to be unplanned (66.4% compared to 32.3%). They are also over three times less likely to be able to pay their bills (36.2% compared to 11.4%). Depression is over twice as high for pregnant women on Medicaid (10.2%) compared to privately insured pregnant women (4.2%).

There are also several measures on husband/partner status that show women on Medicaid/RIte Care are under considerable stress in their family relationships. Their husbands/partners are significantly more likely to have lost their jobs, not wanted the pregnancy, and to have argued or been violent with their wives/partners.

Table 2: Percent of Rhode Island Pregnant/Postpartum Women Who Experienced the following Life Stresses by Insurance Coverage – 2003		
	Rlte Care/ Medicaid (N=4,734)	Private Insurance (N=7,321)
Not trying to get pregnant (unplanned)	66.4	32.3
Family member was hospitalized	26.7	30.3
Separated/Divorced from husband/partner	12.7	2.6
Moved to a New Address	38.6	23.7
Homeless	13.1	1.4
Husband/Partner lost job	20.9	7.0
Pregnant woman lost job	19.3	5.8
Argued more with husband/partner	36.1	20.3
Husband/partner did not want pregnancy	13.3	6.0
Couldn't pay bills	36.2	11.9
Pregnant woman in physical fight	7.5	1.5
Husband/partner went to jail	6.8	1.1
Physically abused by husband/partner	4.9	1.5
Pregnancy was very hard or worst time of life	12.9	7.0
Currently very depressed	10.2	4.2
Currently feel unsafe around husband/partner	5.3	1.9
Plans to move in next three years	61.5	36.0

Data Source: RI Medicaid Research and Evaluation Project
RI-PRAMS, RI Department of Health, 2003 Births

Table 3: Percent of Rhode Island New Mothers who are Able to get Different Types of Social Support by Insurance Coverage – 2003		
	RItE Care/ Medicaid (N=4,734)	Private Insurance (N=7,321)
Someone to loan them \$50	75.8	91.6
Someone to help them if they're sick in bed	84.0	94.5
Someone to talk about their problems to	63.6	85.5
Someone to help if tired/frustrated with baby	86.1	93.4
Someone to take mother and baby to doctor if no transportation	89.5	95.7

Data Source: RI Medicaid Research and Evaluation Project
RI-PRAMS, RI Department of Health, 2003

Table 3 above shows that new mothers on RItE Care are less likely to have social support than new mothers on private insurance. They are less likely to have someone to loan them money, to help them if they are sick, to talk about their problems or to help them with their baby.

**Appendix 1: Maternal and Child Health Indicators by Race
for Medicaid Births 1993-2003**

	1993 [4598]	1994 [4305]	1995 [3510]	1996 [3971]	1997 [3619]	1998 [3618]	1999 [3554]	2000 [4271]	2001 [4533]	2002 [4543]	2003 [4700]	% change
% Entered Care												
1st Trimester	76.6	78.9	80.4	80.6	80.9	81.2	84.2	84.2	85.3	82.4	84.1	9.8
White, NonHispanic	78.0	81.5	82.7	82.7	83.2	84.0	86.7	84.4	86.7	83.6	85.7	9.9
Black, NonHispanic	71.4	71.9	72.6	74.2	74.4	74.0	78.4	84.8	83.0	76.2	80.1	12.2
Hispanic	79.0	79.3	80.1	80.4	79.0	79.5	84.4	84.7	86.2	84.6	85.5	8.2
Asian	66.7	70.3	71.9	71.9	79.2	77.4	75.6	77.8	76.3	76.4	74.2	11.2
% Adequate Prenatal Care	70.1	71.3	76	79.1	80.2	83	82.6	81.3	82.3	81.4	82.2	17.3
White, NonHispanic	81.7	83.8	85.1	86.7	89.1	89.6	89.5	89.2	89.9	89.9	90.9	11.3
Black, NonHispanic	74	74.5	77.3	78.2	77.4	80.2	82.7	82.5	80.7	79.2	81.6	10.3
Hispanic	71.7	73.2	74.6	78.3	81.3	83	83	82.9	83.1	81.6	83	15.8
Asian	72.5	73.5	75.6	77.8	80.7	80.4	78	80.2	82.7	81.1	81.6	12.6
% Mother Smoked During Pregnancy	32.1	31.8	29.2	27.0	25.6	24.3	23.1	24.1	23.0	20.6	20.2	[37.1]
White, NonHispanic	46.3	46.3	41.2	38.2	38.2	37.0	36.1	40.0	37.9	34.6	34.9	[24.6]
Black, NonHispanic	27.8	27.1	24.3	21.6	20.7	19.1	16.8	19.3	19.2	14.7	12.2	[56.1]
Hispanic	11.6	9.9	9.3	8.0	7.1	7.8	6.2	6.4	6.9	5.7	6.2	[46.6]
Asian	14.8	16.4	14.4	17.2	17.6	15.2	20.5	22.3	17.9	16.4	19.1	[29.1]
% Low Birthweight	8.6	8.6	8.2	8.2	8.3	8.8	8.1	8.2	8.5	8.4	9.6	11.6
White, NonHispanic	8.7	7.8	7.7	7.8	8.3	8.9	7.3	8.2	8.3	7.7	8.5	[2.3]
Black, NonHispanic	12.5	12.3	12.2	11.1	10.1	10.1	12.7	12.3	11.6	11.3	11.5	[8]
Hispanic	6.0	8.0	6.5	7.8	7.5	7.4	7.4	6.3	7.3	7.1	9.6	60.0
Asian	9.1	8.0	12.3	8.0	9.9	12.7	9.8	9.7	10.2	12.8	12.3	35.2

**Appendix 1: Maternal and Child Health Indicators by Race
for Medicaid Births 1993-2003 (page 2)**

	1993 [4598]	1994 [4305]	1995 [3510]	1996 [3971]	1997 [3619]	1998 [3618]	1999 [3554]	2000 [4271]	2001 [4533]	2002 [4543]	2003 [4700]	% change
% of Births with Short Interval	40.8	38.2	30.0	28.6	29.8	30.7	28.9	29.7	30.3	31.3	27.9	[31.6]
White, NonHisp	38.5	35.9	30.1	28.0	31.0	31.2	27.7	32.0	32.7	33.0	27.5	[28.6]
Black, NonHisp	47.4	39.5	30.6	31.2	27.0	32.7	29.4	25.1	28.6	30.6	28.5	[39.9]
Hispanic	38.3	38.3	28.0	28.1	29.0	28.7	29.1	28.0	27.7	28.6	24.1	[37.1]
Asian	52.8	51.3	37.5	31.6	27.7	32.4	37.4	33.1	30.7	34.7	38.3	[27.5]
% of Births to Teens	23.2	23.1	20.8	19.9	19.8	19.7	19.2	19.6	19.2	17.7	16.6	[28.5]
White, NonHisp	21.8	20.6	19.5	17.2	17.4	18.2	18.1	18.3	17.8	16.3	15.5	[28.9]
Black, NonHisp	28.5	29.7	25.1	22.0	19.2	20.3	18.3	19.5	20.1	16.3	18.1	[36.5]
Hispanic	22.6	24.4	22.3	23.1	23.5	20.2	19.2	21.2	19.7	18.7	17.4	[23]
Asian	23.9	22.1	19.1	27.9	25.1	28.3	28.6	20.9	24.2	23.8	16.8	[29.7]
% of Repeat Teen Births	26.8	26.0	23.3	25.8	23.0	24.2	24.9	24.1	22.0	22.6	19.5	[27.2]
White, NonHisp	22.7	22.2	16.8	22.4	16.7	20.5	23.7	21.5	18.4	19.8	18.1	[20.3]
Black, NonHisp	34.7	27.8	29.9	36.8	26.3	25.8	27.3	23.5	24.6	22.6	14.1	[59.4]
Hispanic	29.0	29.7	33.3	24.8	31.0	25.4	26.8	28.0	23.9	22.6	24.6	[15.2]
Asian	26.7	30.9	20.5	32.3	20.4	38.1	21.1	19.6	27.9	33.3	11.8	[55.8]



Profiles and Trends of the Uninsured in Rhode Island - 2004 Update

TABLES AND FIGURES

November 2005

<p style="text-align: center;">Table 1 The Number of Non-Elderly Uninsured in Rhode Island Almost Doubled from 2000-2004: The Largest Increase was Seen in Children</p>						
	2000	2001	2002	2003	2004	% Increase
<18 years old						
Number Uninsured	6,196	11,152	11,648	12,887	18,339	196%
Percent Uninsured	2.5%	4.5%	4.7%	5.2%	7.4%	
18-64 years old						
Number Uninsured	55,804	69,481	89,591	91,935	97,234	74%
Percent Uninsured	8.6%	10.7%	13.8%	14.2%	15.0%	
Total <65						
Number Uninsured	62,000	80,633	101,239	104,822	115,573	86%
Percent Uninsured	6.9%	9%	11.3%	11.7%	12.9%	

Data Source: Medicaid Research & Evaluation Project, October 2005
Census 2000, CPS September annual estimates

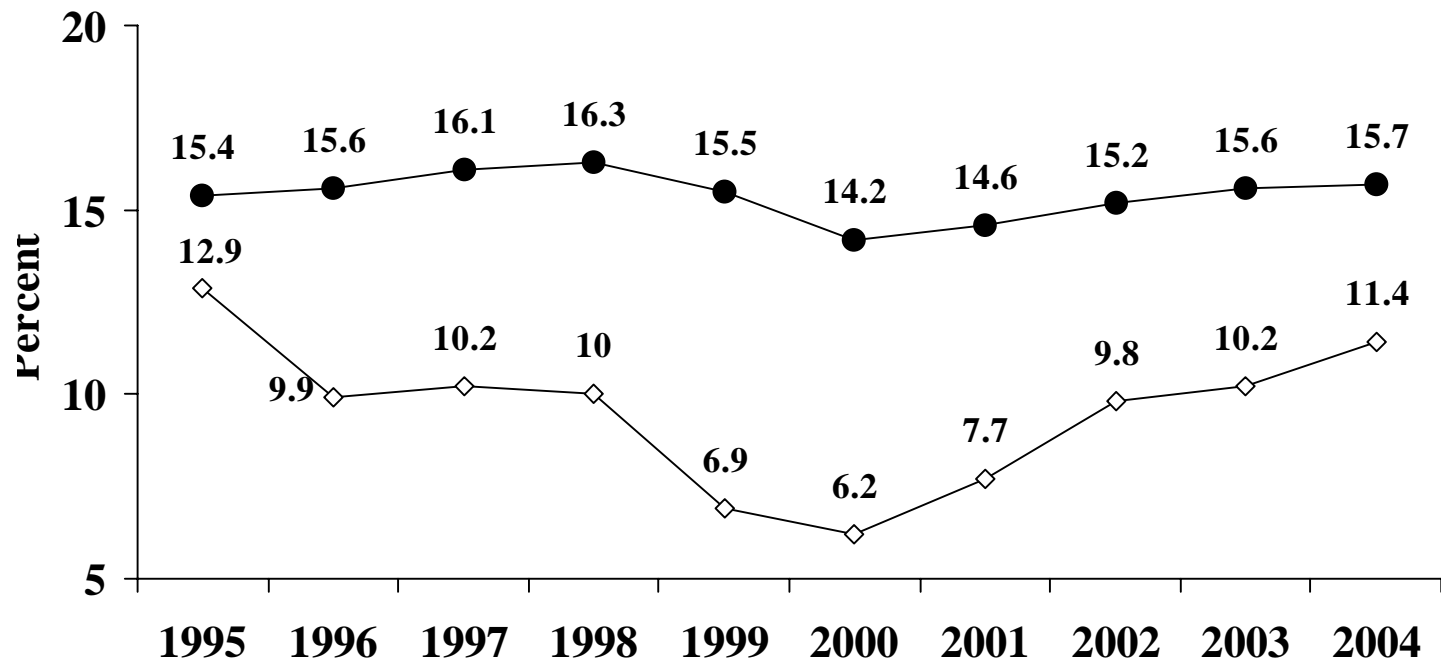
* RI Census 2000 population numbers by age used for estimates:

<18 (n=247,822)

18-64 (n=648,105)

Total <65 (n=895,917)

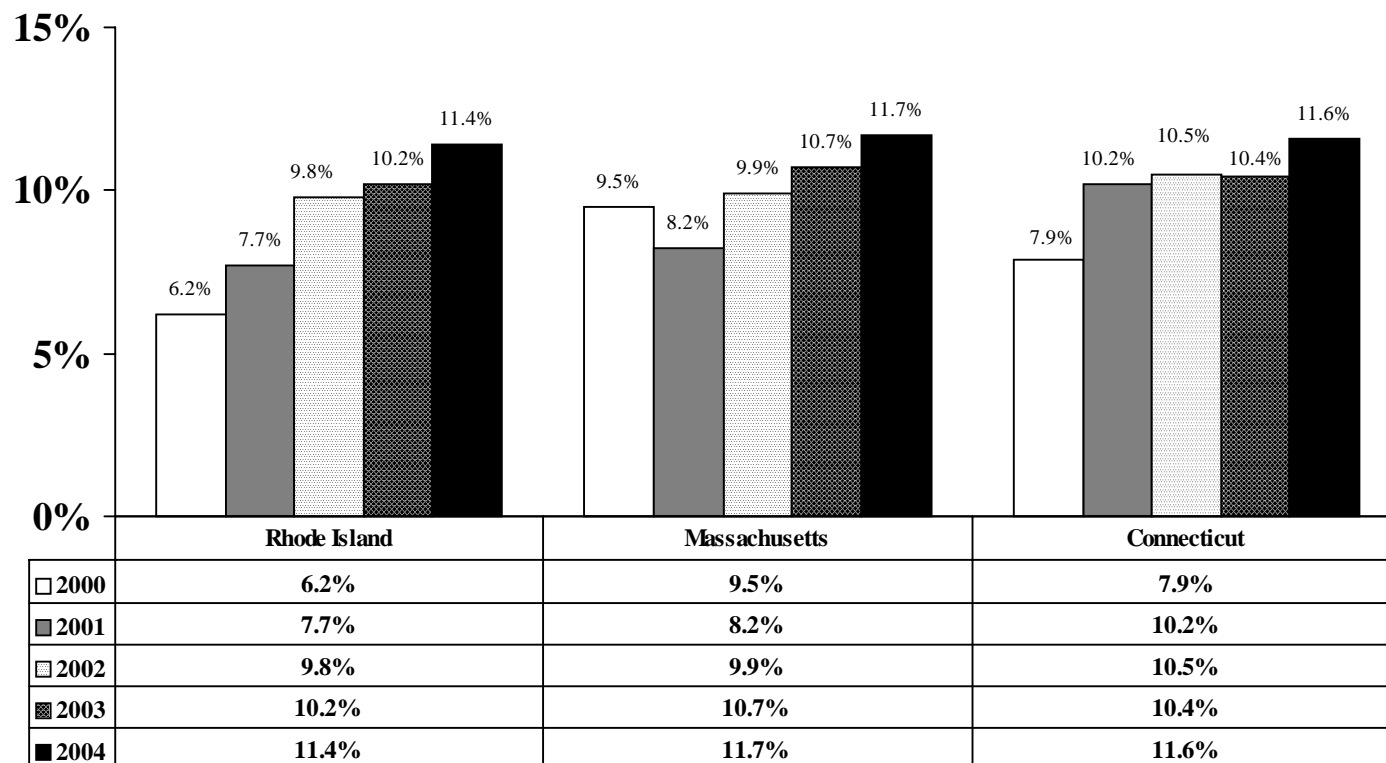
Figure 1
The Percent of Uninsured in the United States has Remained Stable for the
Past Five Years Whereas Rhode Island's Rate has been Steadily Rising
 1995-2004 – All Ages



RI Rank	6 th	4 th	5 th	4 th	1 st	1 st	1 st	3 rd	3 rd	9 th
	<div> <div>● United States</div> <div>◇ Rhode Island</div> </div>									

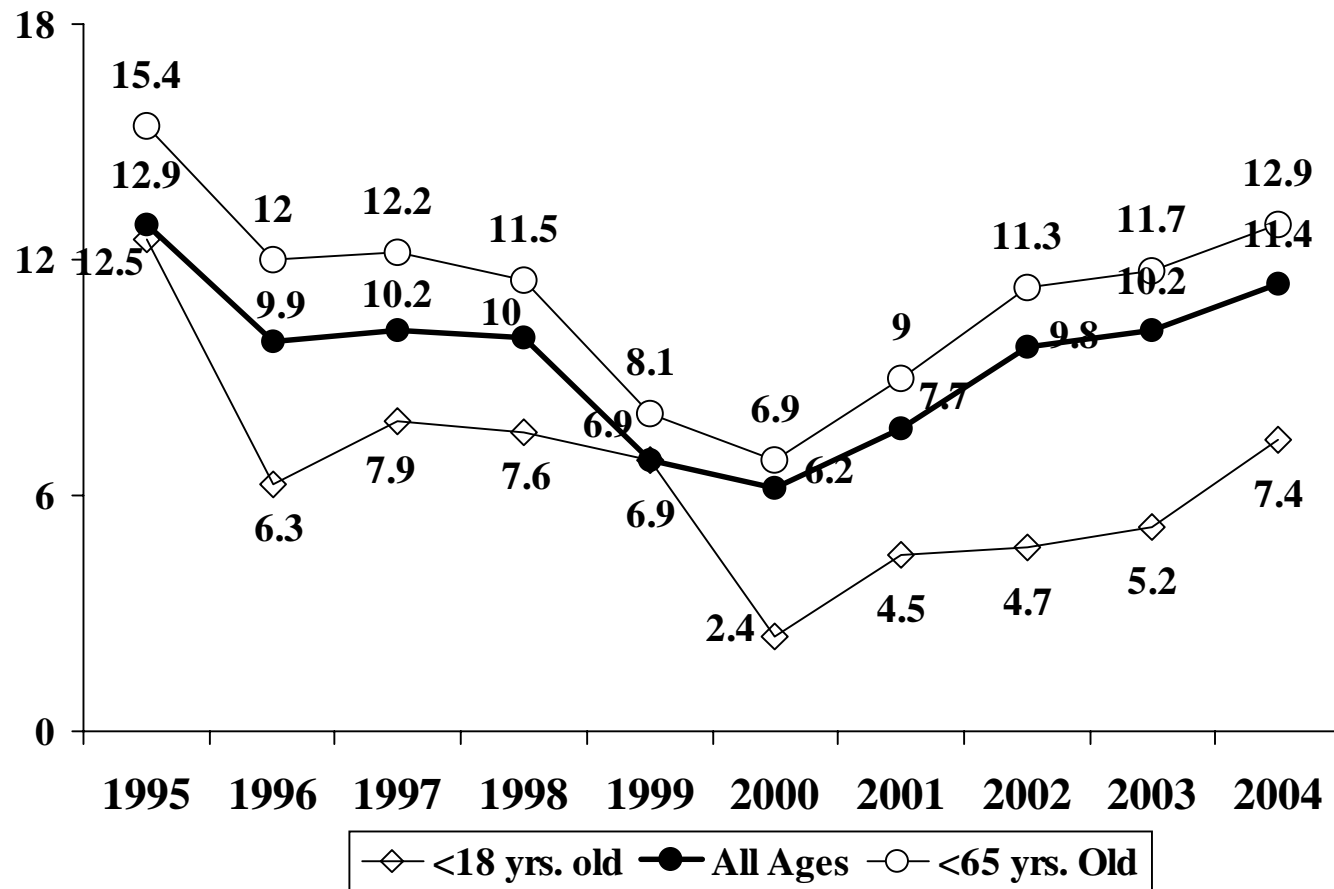
Data Source: Medicaid Research and Evaluation Project
 US Bureau of Census, Current Population Survey – 1995 – 2004 (September estimates)

Figure 2
**Rhode Island, Massachusetts and Connecticut had Similar Rates of Uninsurance in 2004
but Rhode Island had the Steepest Rise from 2000-2004**



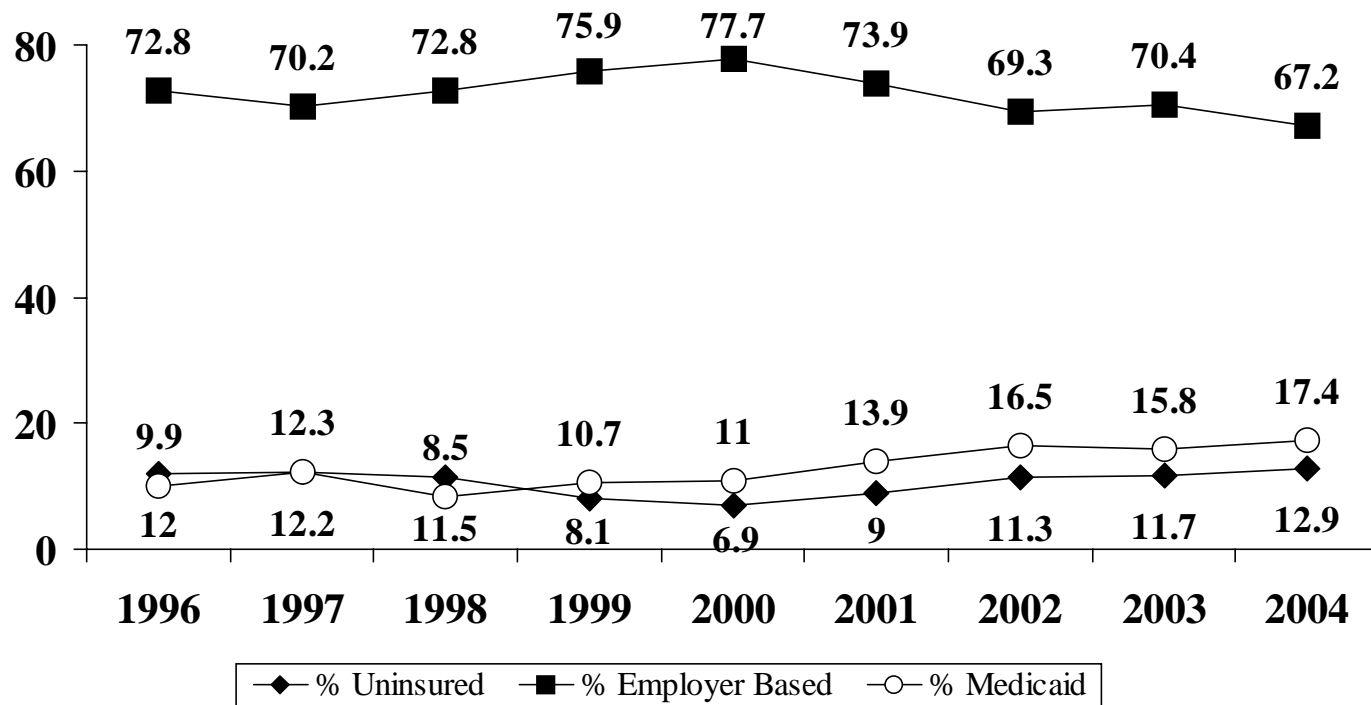
Source: RI Medicaid Data Archive, U.S. Census Bureau
September Estimates, Current Population Reports

Figure 3
The Rise in RI Uninsured After 2000 Was Seen in All Age Groups



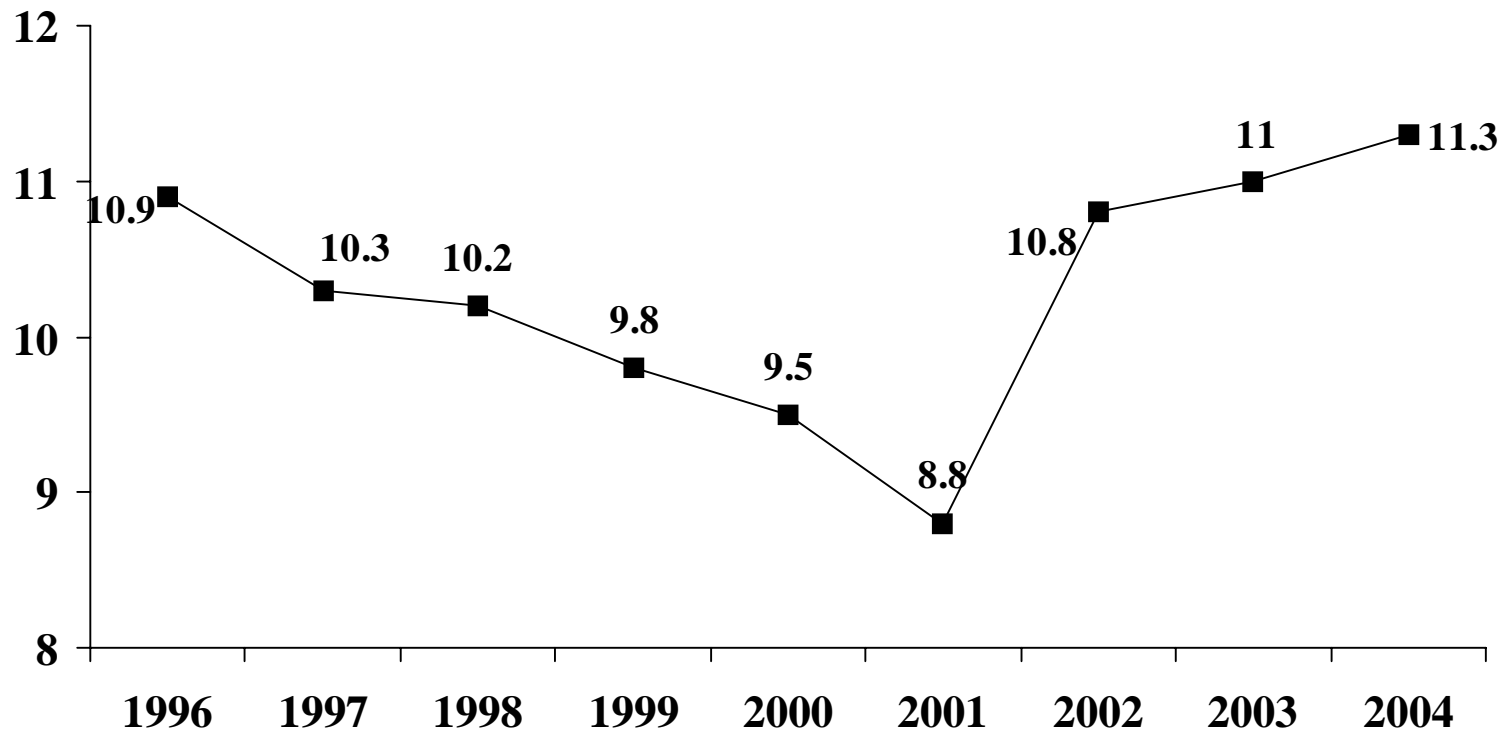
Data Source: Medicaid Research and Evaluation Project
 US Bureau of the Census, Current Population Surveys 1995-2004 (September estimate, 2005)

Figure 4
The Decrease in Employer Based Health Coverage from 77.7% to 67.2%
Contributed the Most to RI's Increase in Uninsured from 2000 to 2004



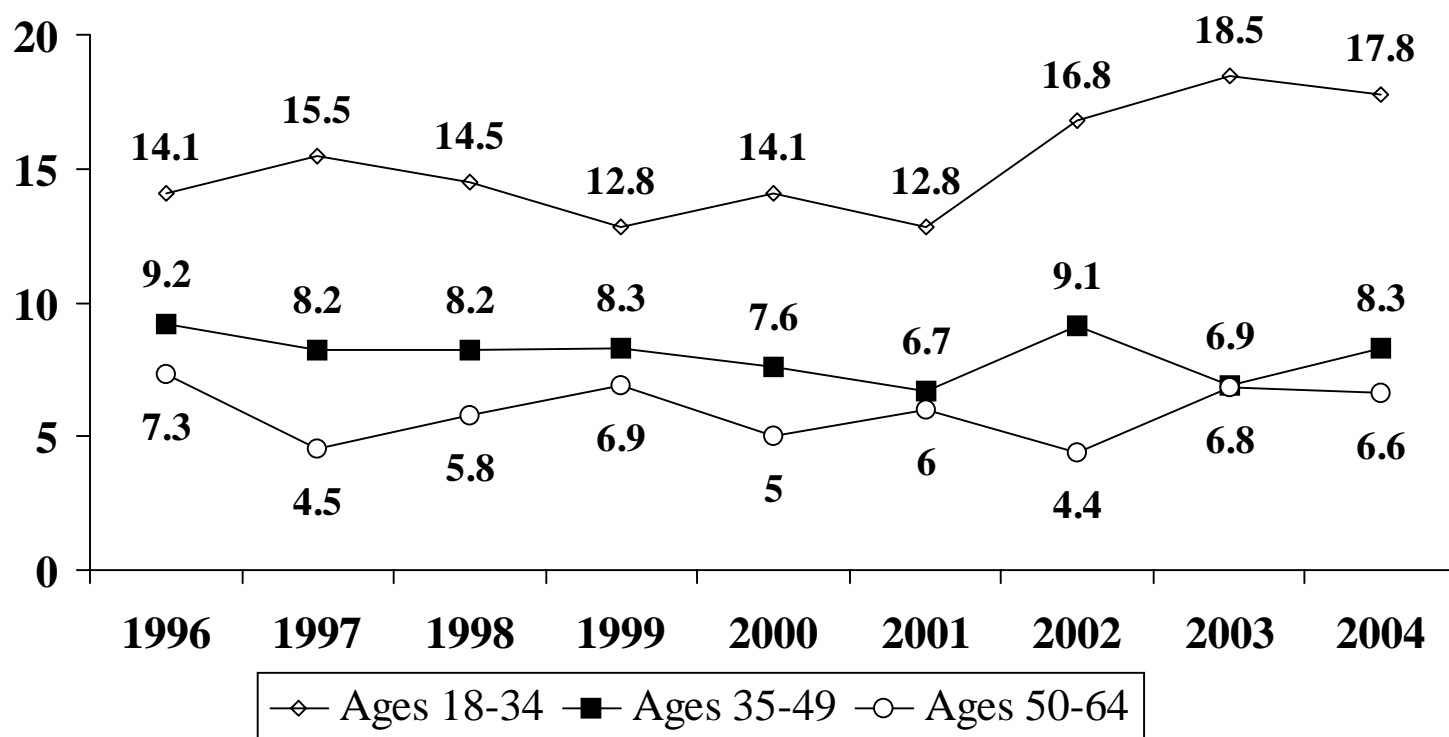
Data Source: Medicaid Research and Evaluation Project
 US Bureau of the Census, Current Population Surveys 1996-2004 (September estimate, 2005)
 Age Group = <65 years old

Figure 5
In 2004 the Proportion of Uninsured Working-Aged
Rhode Islanders was the Highest in Ten Years



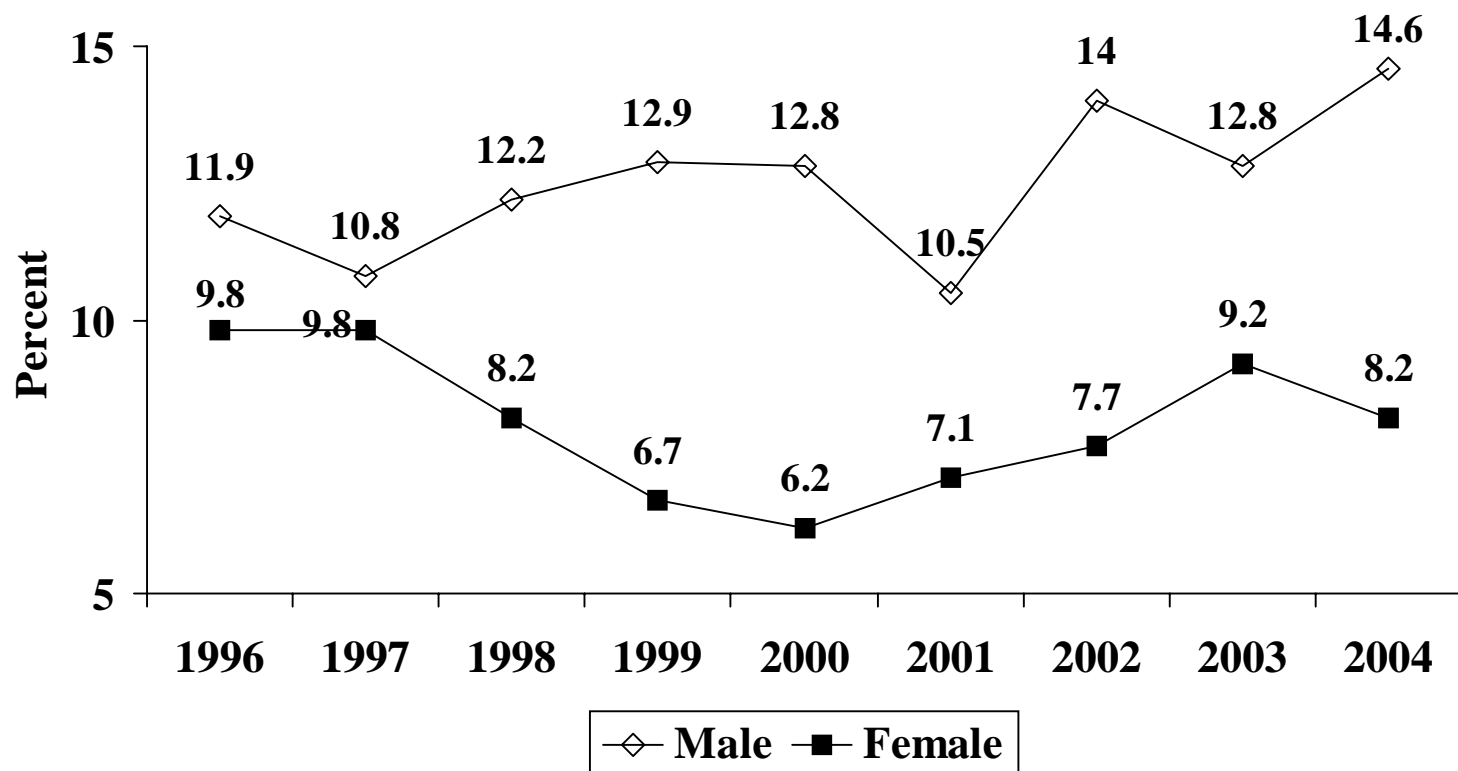
Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2004, RI Department of Health
Age Group = 18-64 years old

Figure 6
The Proportion of Uninsured has Consistently
been higher for the Youngest Age Group:
Almost 1 in 5 Rhode Islanders in this Age Group is Uninsured



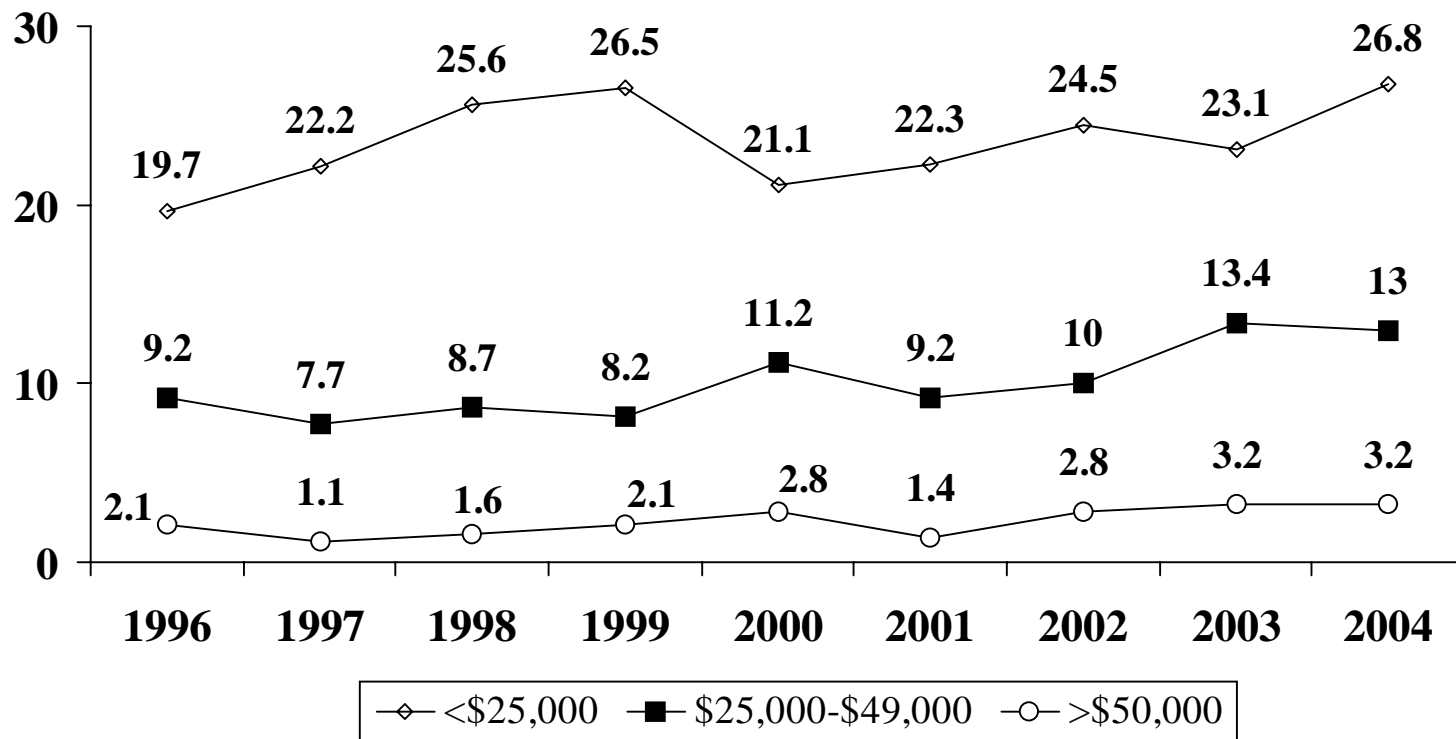
Data Source: Medicaid Research and Evaluation Project
 Behavioral Risk Factor Surveillance System 1996-2004, RI Department of Health

Figure 7
Rhode Island Males on Average are Twice as Likely to be Uninsured



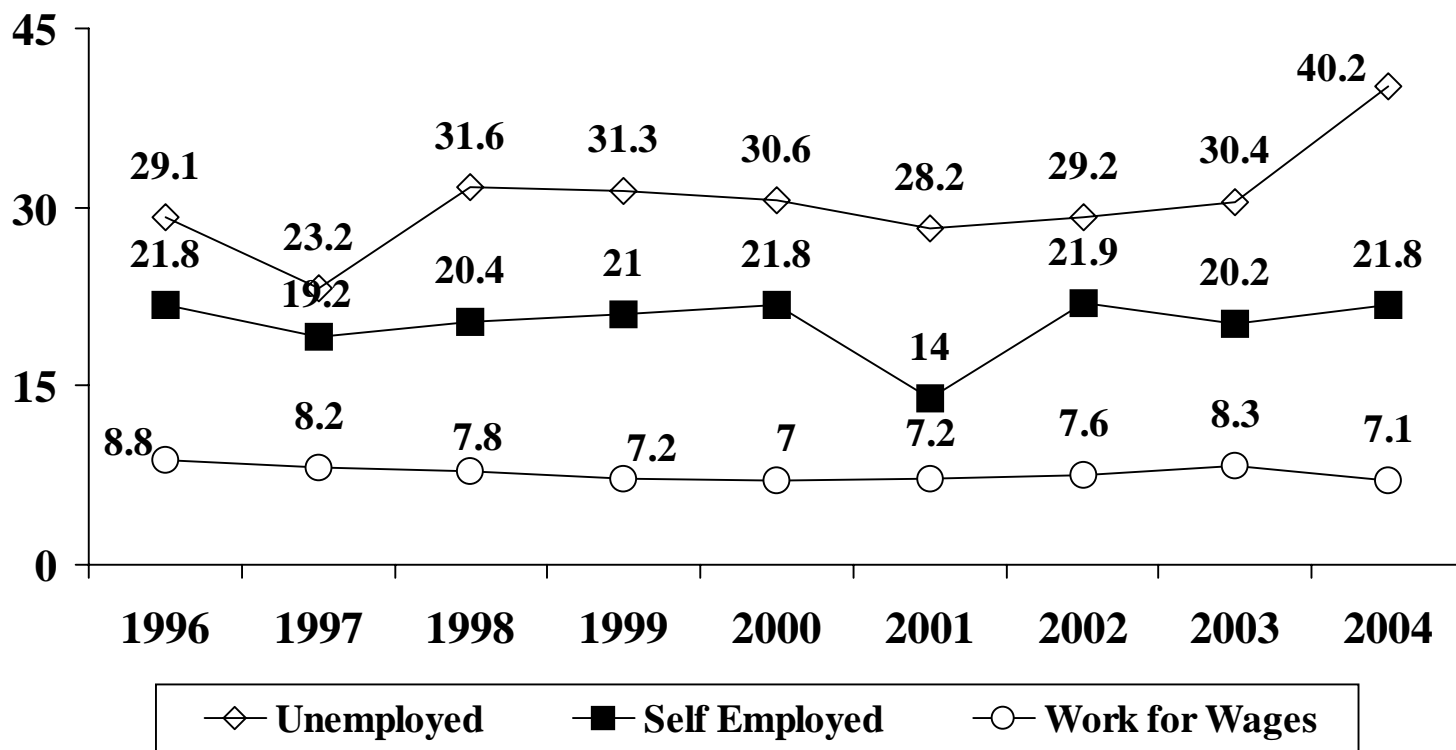
Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2004, RI Department of Health
Age Group = 18-64 years old

Figure 8
**Lower Income Rhode Islanders are Twice as Likely to be
Uninsured Compared to Middle Income Rhode Islanders**



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2004, RI Department of Health
Age group = 18-64 years old

Figure 9
**Unemployed Rhode Islanders Have Consistently had Highest Rate of
 Uninsurance and this Rate is Rising**



Data Source: Medicaid Research and Evaluation Project
 Behavioral Risk Factor Surveillance System 1996-2004, RI Department of Health
 Age group = 18-64 years old

Figure 10
**RI Uninsured in 2004 are Primarily Young, Male,
 Employed and Low Income**

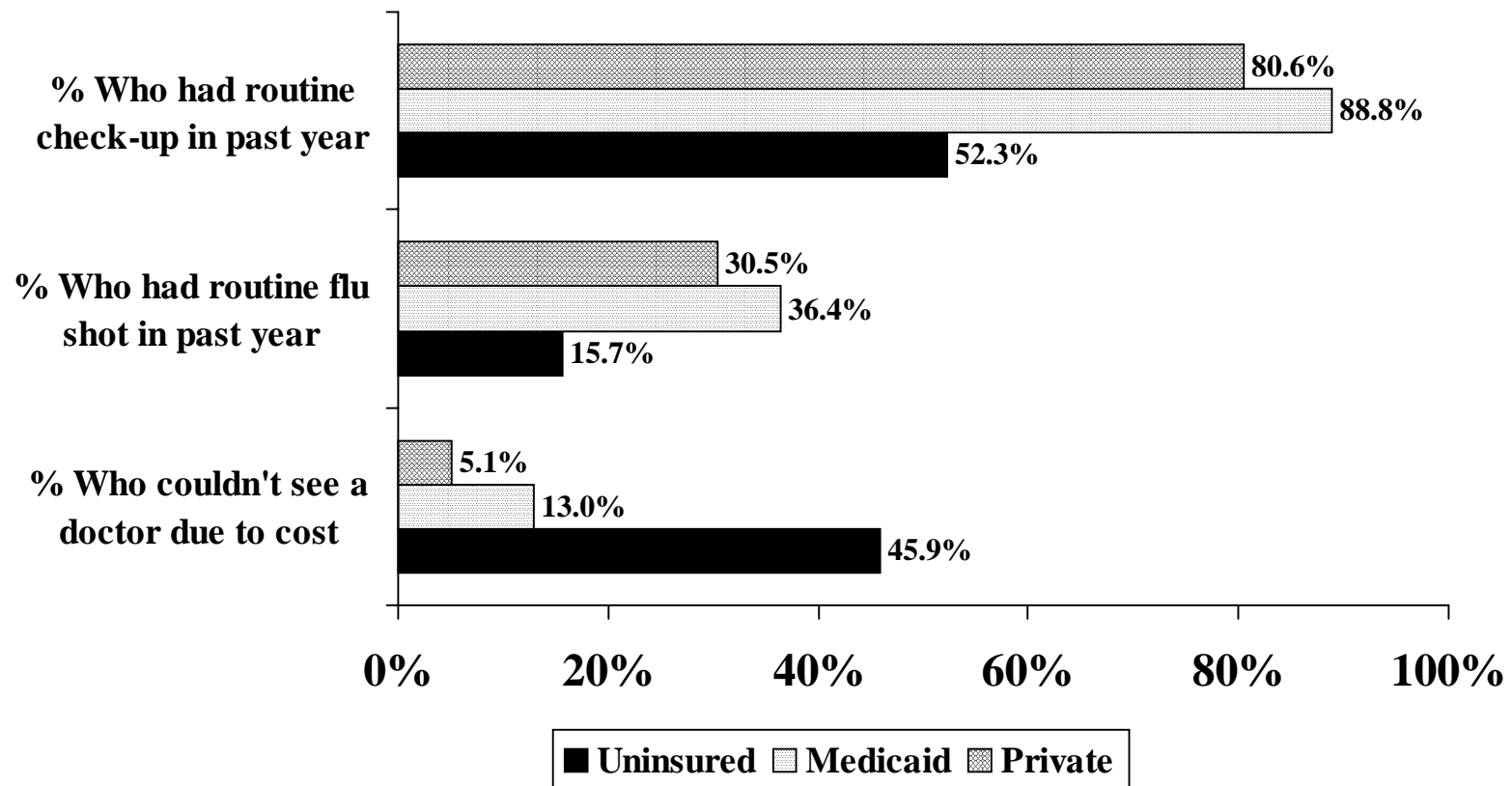


Data Source: Medicaid Research and Evaluation Project; Behavioral Risk Factor Surveillance System 1996-2004, RI DOH

¹ Note: Estimate of Number of Uninsured is from Census, CPS (September 2005 estimates) and proportions are from 2004 BRFSS

Age Group = 18-64 years old, n=97,234

Figure 11
Access to Health Care is Worse for The Uninsured



Data Source: Medicaid Research and Evaluation Project
Behavioral Risk Factor Surveillance System 1996-2004, RI Department of Health
Age Group = 18-64 years old

Table 2: Changes in Number of Uninsured form 2000-2004 Increased in All Groups

	CY2000	CY2004	% Increase
Total	55,804	97,234	74.2%
Age Group			
18-34	32,004	55,200	72.5%
35-54	16,803	26,574	58.2%
55-64	6,998	15,470	121.1%
Sex			
Male	37,438	60,664	62.0%
Female	18,365	36,570	99.6%
Employment Status			
Work for wages	29,844	39,389	32.0%
Self Employed	9,777	21,819	123.2%
Unemployed	8,627	24,950	189.2%
Not in Workforce *	7,556	11,075	46.6%
Income			
<\$25,000	26,289	49,103	86.8%
\$25,000-49,000	22,204	31,951	43.9%
≥\$50,000*	7,310	16,180	121.3%

Data Source: Medicaid research and Evaluation Project; Behavioral Risk Factor Surveillance System 1996-2004,
RI DOH Note: estimate of number of uninsured is from Census, CPS (Sep 05 estimates) & proportions are from
2004 BRFSS * = small numbers <50 in cell

Characteristics of Uninsured Rhode Islanders in Three Age Groups

- Demographics
- Access to Care
- Lifestyle
- Health Status

PREPARED BY:

Karen Bogen, PhD

RI Medicaid Research and Evaluation Project

June 2005

Table of Contents

Section 1: Overview Page

Purpose	2
Methods.....	3

Section 2: Demographics

2-1. Marital Status	10-11
2-2. Education	12-13
2-3. Gender.....	14-15
2-4. Household Size	16-17
2-5. Income	18-19
2-6. Labor Force Status	20-21

Section 3: Access to Care

3-1. No usual place to go or go to ED for routine care	24-25
3-2. Did not see doctor in past 12 months.....	26-27
3-3. No routine doctor visit in past 12 months.....	28-29
3-4. Did not get medical care from doctor due to cost	30-31
3-5. Did not get prescription due to cost	32-33

Table of Contents

Section 4: Lifestyle	Page
4-1. Currently smoke.....	36-37
4-2. Obese.....	38-39
 Section 5: Health Status	
5-1. Overall health status	42-43
5-2. Health conditions (asthma, diabetes, arthritis, depression)	44-45
5-3. Disabled	46-47

Section 1: Overview

PURPOSE

The purpose of this chartbook is to provide information about the uninsured in Rhode Island in three different age groups – 18-34, 35-49, and 50-64. Included in this report are the demographics of the uninsured, their access to care, and their health status. These charts do not cover the youngest and the oldest residents because they tend to be insured at a very high rate (over 96% for those under 18 and over 98% for those over 65 in 2001). Instead, the goal of these charts is to provide DHS with population estimates of the uninsured, in order to develop programs to improve health insurance coverage for the age groups most likely to be without coverage.

METHODS

This report uses two data sources to describe the uninsured in Rhode Island and to make population estimates. The data source for all of the percentages shown in these charts is the 2001 RI Health Interview Survey (HIS).¹ The data source for the population estimates (the age group N's shown on the charts) is the 2004 data collection of the Current Population Survey, Annual Social and Economic Supplement from the Census Bureau – the reference year for those data is 2003.²

1. 2001 is the most currently available RI HIS. There was a new wave of data collected in 2004, but the data are not yet publicly available for analysis. For detailed information about the RI HIS survey design and data collection, please see the following technical documentation: Rhode Island Department of Health 2001 Interview Survey, Technical Documentation, Brian Robertson, Market Decisions, May 2002.
2. The Census Bureau provided a special run of insurance status by age group for Rhode Island. Additional information about the CPS is available at www.census.gov.

METHODS

It is unconventional to combine these two data sources, particularly because they are two years apart. However, there is evidence from national surveys that the situation of the uninsured is changing, specifically that the rate of non-coverage is increasing and that coverage through employment-based health insurance is decreasing.³ Since we do not have up-to-date measures from the RI HIS, we thought it would be preferable to show population estimates from the Census Bureau for 2003, to give planners the most up to date numbers on which to develop programs for the uninsured.

3. See <http://www.census.gov/hhes/www/hlthins.html>.

METHODS

The risk in applying the 2001 RI HIS percentage distributions to the 2003 CPS population estimates is that the percentage distributions may have changed. However, these are the most current distributions available and, thus, the best description of the uninsured.

The following table on the next page summarizes the population estimates from the RI HIS and the CPS, for comparison. The CPS estimates from 2003, compared to the RI HIS estimates from 2001, show lower rates of insurance coverage in all age groups except 65 and older.

METHODS

Estimates of Rhode Island Insurance Coverage by Age from Two Data Sources

	Current Population Survey, Annual Social and Economic Supplement, 2004 (data for reference year 2003)			2001 RI HIS		
AGE	Insured	Uninsured	Total	Insured	Uninsured	Total
0 to 17	238,287 (94.8%)	13,064 (5.2%)	251,351 (100%)	237,068 (96.2%)	9,378 (3.8%)	246,446 (100%)
18 to 34	187,303 (80.5%)	45,516 (19.5%)	232,819	197,624 (86.7%)	30,386 (13.3%)	228,010
35 to 49	210,520 (87.0%)	31,330 (13.0%)	241,850	220,177 (92.7%)	17,396 (7.3%)	237,573
50 to 64	166,417 (91.1%)	16,188 (8.9%)	182,605	139,252 (93.4%)	9,801 (6.6%)	149,053
65+	143,084 (99.0%)	1,479 (1.0%)	144,563	139,472 (98.8%)	1,737 (1.2%)	141,209
Totals	945,612 (89.8%)	107,576 (10.2%)	1,053,189	933,593 (93.1%)	68,697 (6.9%)	1,002,290*
				* The total does not include 7,128 cases (53 unweighted) for whom the insurance information is missing. If they were included, the total would be 1,009,418.		

METHODS

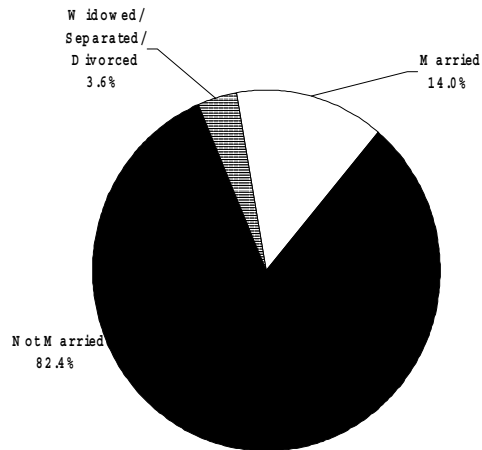
The main source of data for this report is the 2001 RI HIS, which is based on a representative sample of telephone households in Rhode Island. The sample excludes group-quarter households (such as dorms and military barracks and institutions containing nine or more persons) as well as households without telephones.

In 2001, there were 2,600 households interviewed with a total of 6,877 individuals. The analyses in this report are based on individuals (not households) and are limited to those between ages 18 and 64 (4,116 unweighted cases). The data are weighted to compensate for different probabilities of selection at the sampling stage of the project (described in the HIS technical documents). The total number of weighted cases with information about insurance coverage is 614,636.

Section 2: Demographics

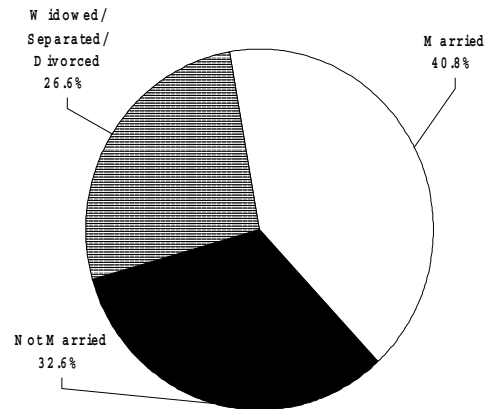
Not surprisingly, the younger group of uninsured Rhode Islanders, age 18-34, are mostly unmarried – over four out of five (82%). The marital status of the older group, age 50-64, is more mixed, with about half (49%) widowed, divorced, or separated, about two out of five (40%) married, and the remainder unmarried. The middle age group (age 35-49), is most evenly divided among the marital statuses, though the majority are married (about 41%).

2-1. Marital status of uninsured Rhode Islanders: *the younger group is predominantly unmarried*



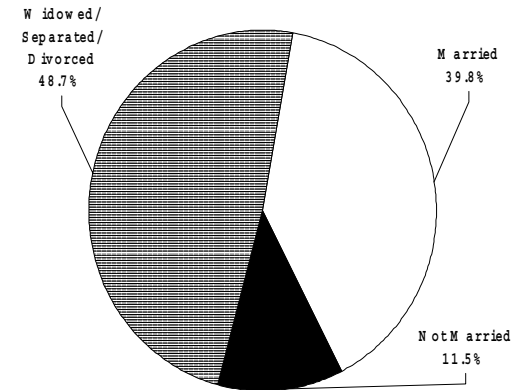
Age 18-34

N=45,516



Age 35-49

N=31,330

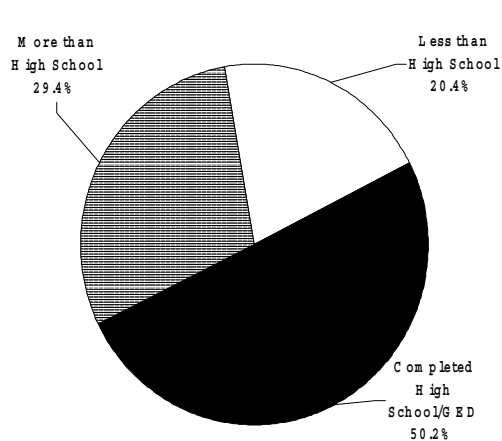


Age 50-64

N=16,188

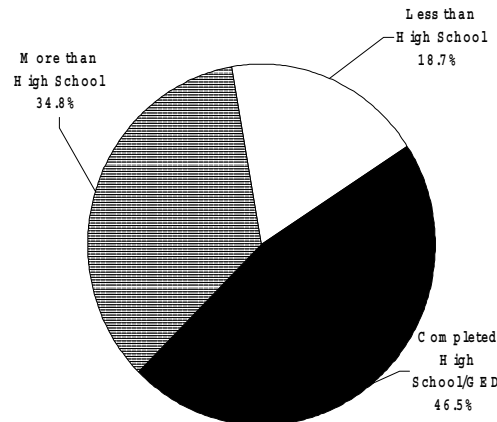
The education categories look very similar for the younger and middle age groups of uninsured Rhode Islanders, age 18-34 and 35-49. Nearly four out of five in each group have completed high school or higher education. For the older group (age 50-64), however, only about three out of five have done so. For the older group of uninsured, over one-third (about 38%) have less than a high school education.

2-2. Education of uninsured Rhode Islanders: *the younger and middle groups are similar, but the older group has a higher percentage with less than high school education*



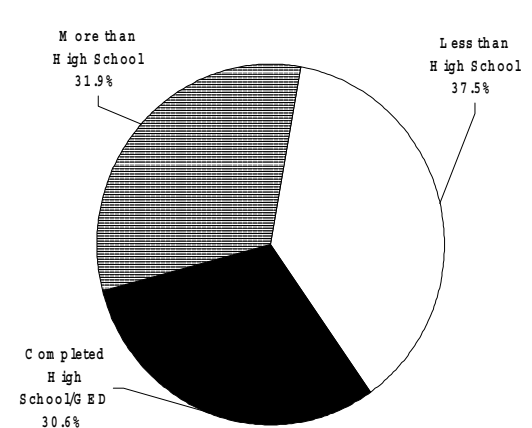
Age 18-34

N=45,516



Age 35-49

N=31,330

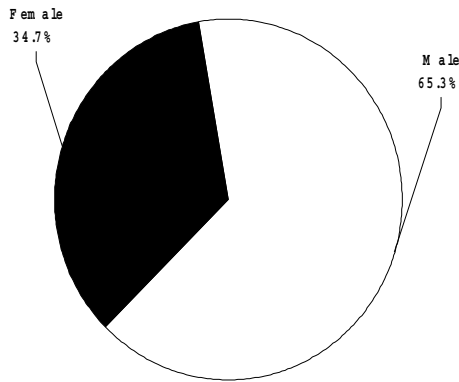


Age 50-64

N=16,188

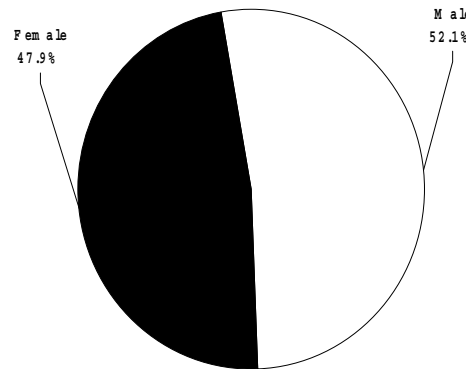
In the younger group of uninsured Rhode Islanders, age 18-34, nearly two-thirds are male (65%), while for the older group (age 50-64), the majority flips slightly towards female (53%).

2-3. Gender of uninsured Rhode Islanders: *the younger group is nearly two-thirds male, while the older group has over half females*



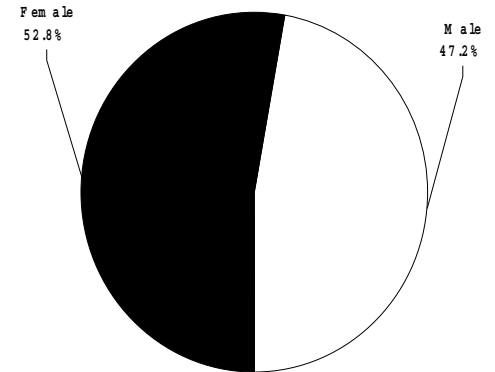
Age 18-34

N=45,516



Age 35-49

N=31,330

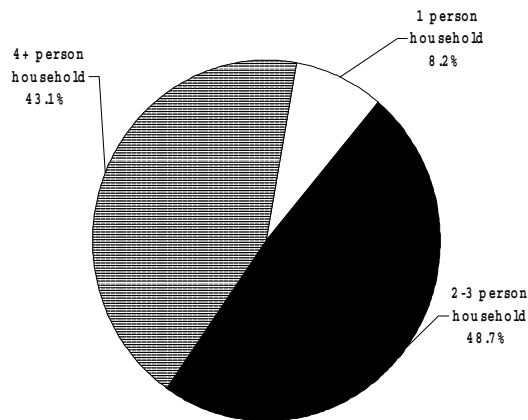


Age 50-64

N=16,188

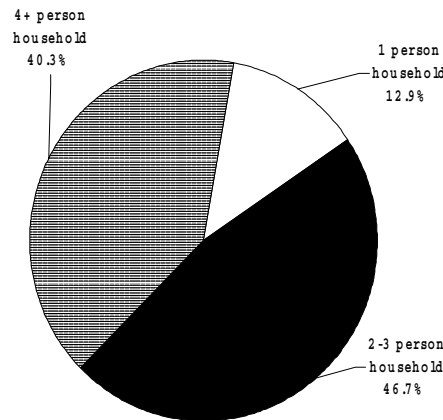
For the younger and middle-aged groups of uninsured Rhode Islanders, age 18-34 and 35-49, about two out of five households have four or more persons in them. For the older group (age 50-64), it is half that, about one out of five (21%). The older group is much more likely than the other age groups to live in single-person households (nearly one-fourth).

2-4. Household size of uninsured Rhode Islanders: *the older group is very different from the other two age groups, with more single-person households and fewer large households*



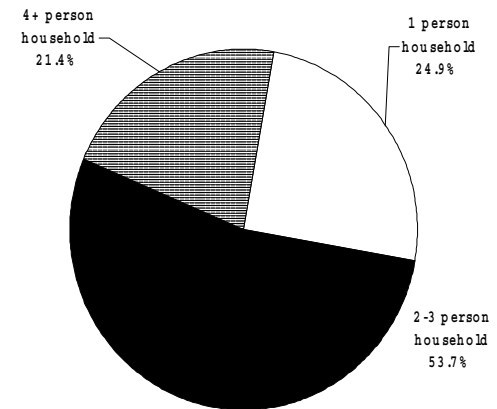
Age 18-34

N=45,516



Age 35-49

N=31,330

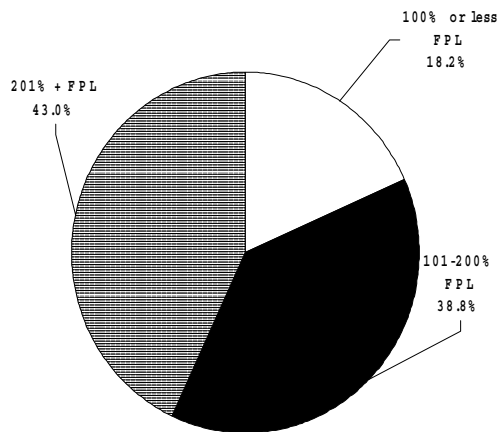


Age 50-64

N=16,188

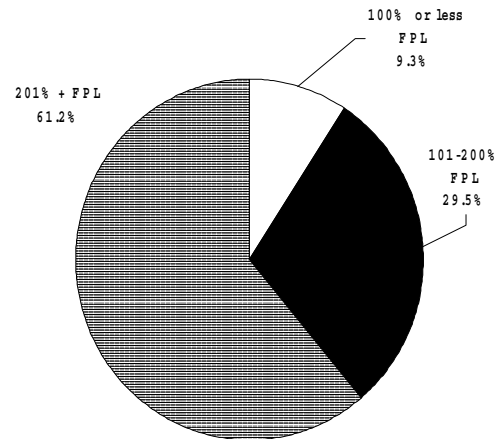
The older group of uninsured Rhode Islanders, age 50-64, has the highest percentage in poverty at about one-fourth (25%). However, when you look at poor and near-poor combined (200% of poverty or below), the younger group of uninsured Rhode Islanders appears slightly more in need. Specifically, nearly three out of five of the younger group (about 57%) are poor or near poor, while about half (50%) of the older group are. The middle age group (age 35-49) appears the most comfortable, with three out of five above the poor/near-poor cutoff of 200% above poverty.

2-5. Income of uninsured Rhode Islanders: *the older group has the highest percentage in poverty, at about one-fourth*



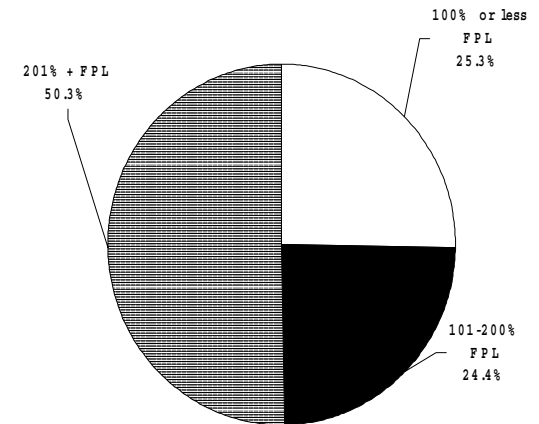
Age 18-34

N=45,516



Age 35-49

N=31,330



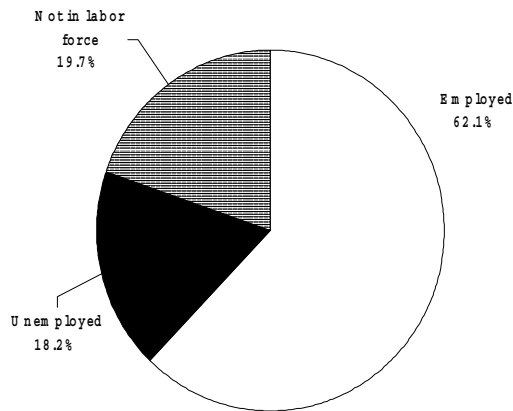
Age 50-64

N=16,188

The older group of uninsured Rhode Islanders, age 50-64, has the lowest percentage of employed (50%), while the other two groups each has over 60% employed.

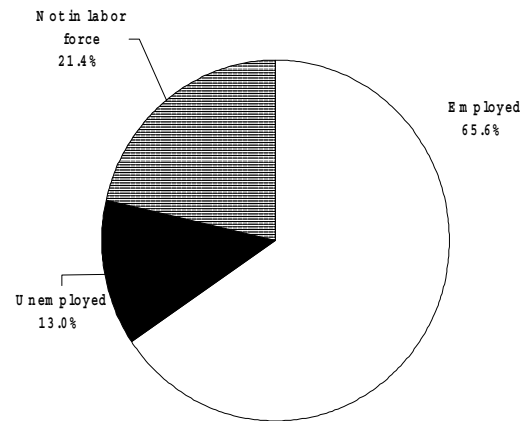
Correspondingly, the older group has the highest percentage not in the labor force (about 33%). The percentage of unemployed is not as variable among the three age groups, with the range from about 13% for the middle aged group to 17-18% for the older and younger groups.

2-6. Labor Force status of uninsured Rhode Islanders: *nearly one-third of the older group is not in the labor force and only half are employed*



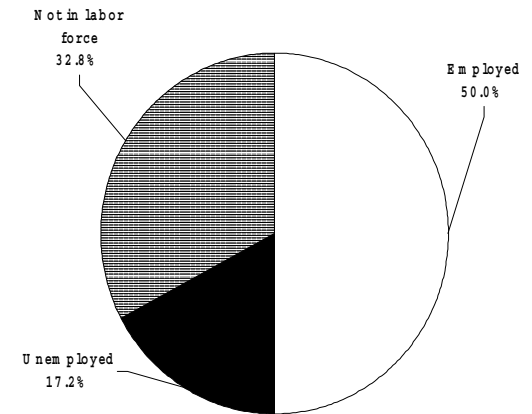
Age 18-34

N=45,516



Age 35-49

N=31,330



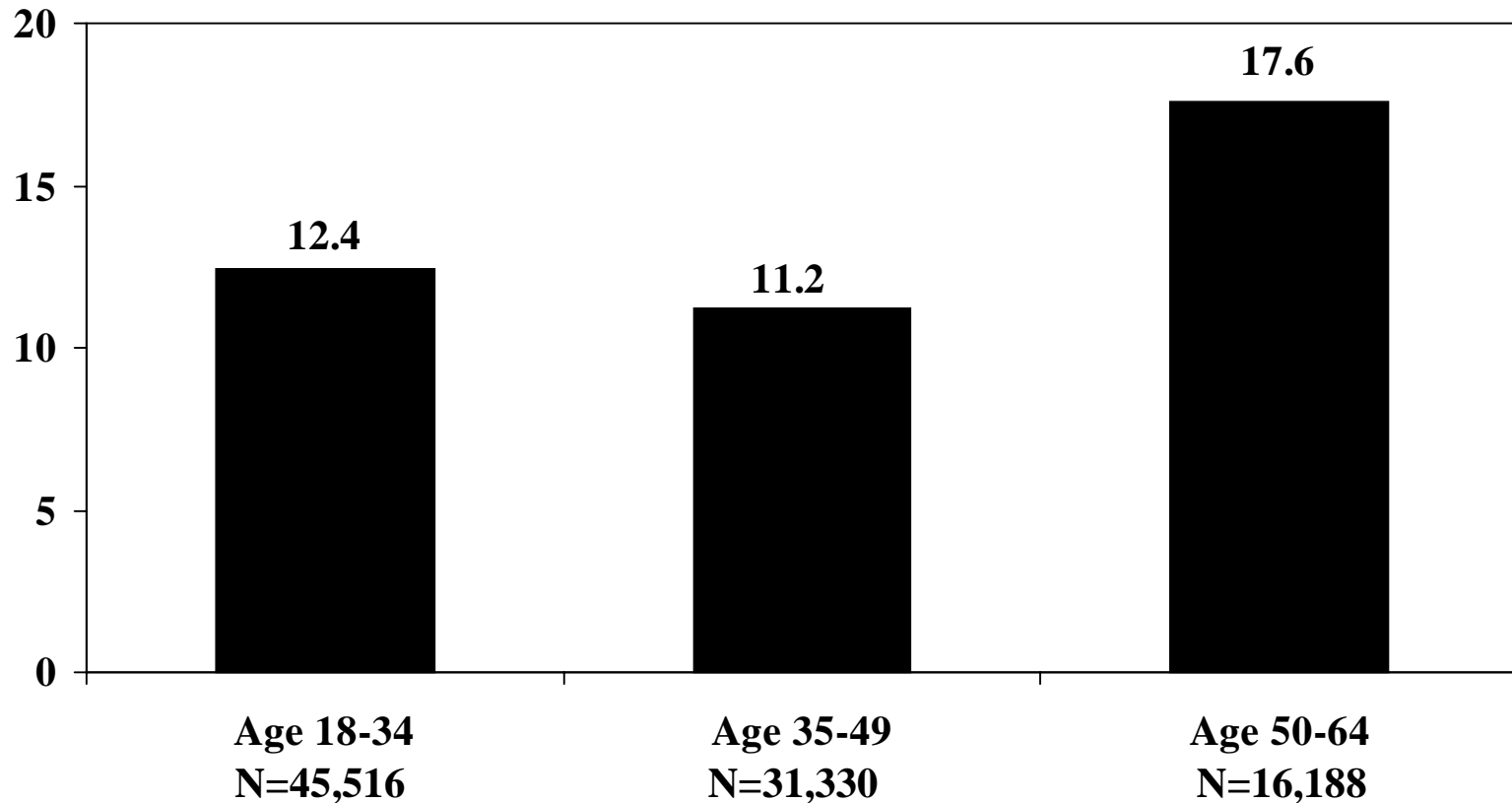
Age 50-64

N=16,188

Section 3: Access to Care

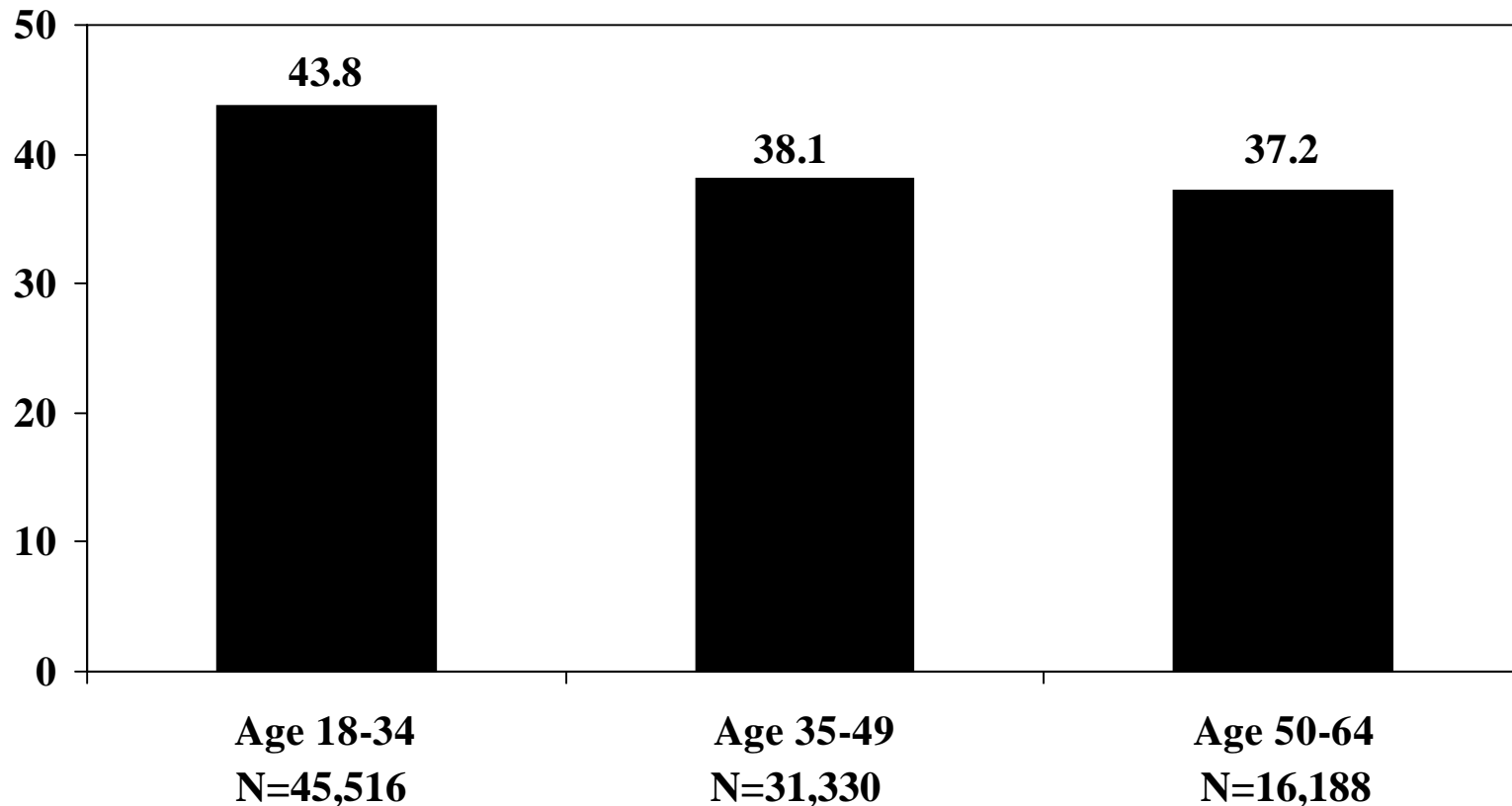
The older group of uninsured Rhode Islanders, age 50-64, is the most likely to report no usual place they go for routine care, or they report going to the Emergency Department (about 18%). The other two groups, age 18-34 and 35-49, are somewhat lower at about 12% and 11%, respectively.

3-1. Percent of uninsured Rhode Islanders (18-64) who have no usual place or go to the ED for routine care: *the older group is most likely to report no usual place or ED for routine care*



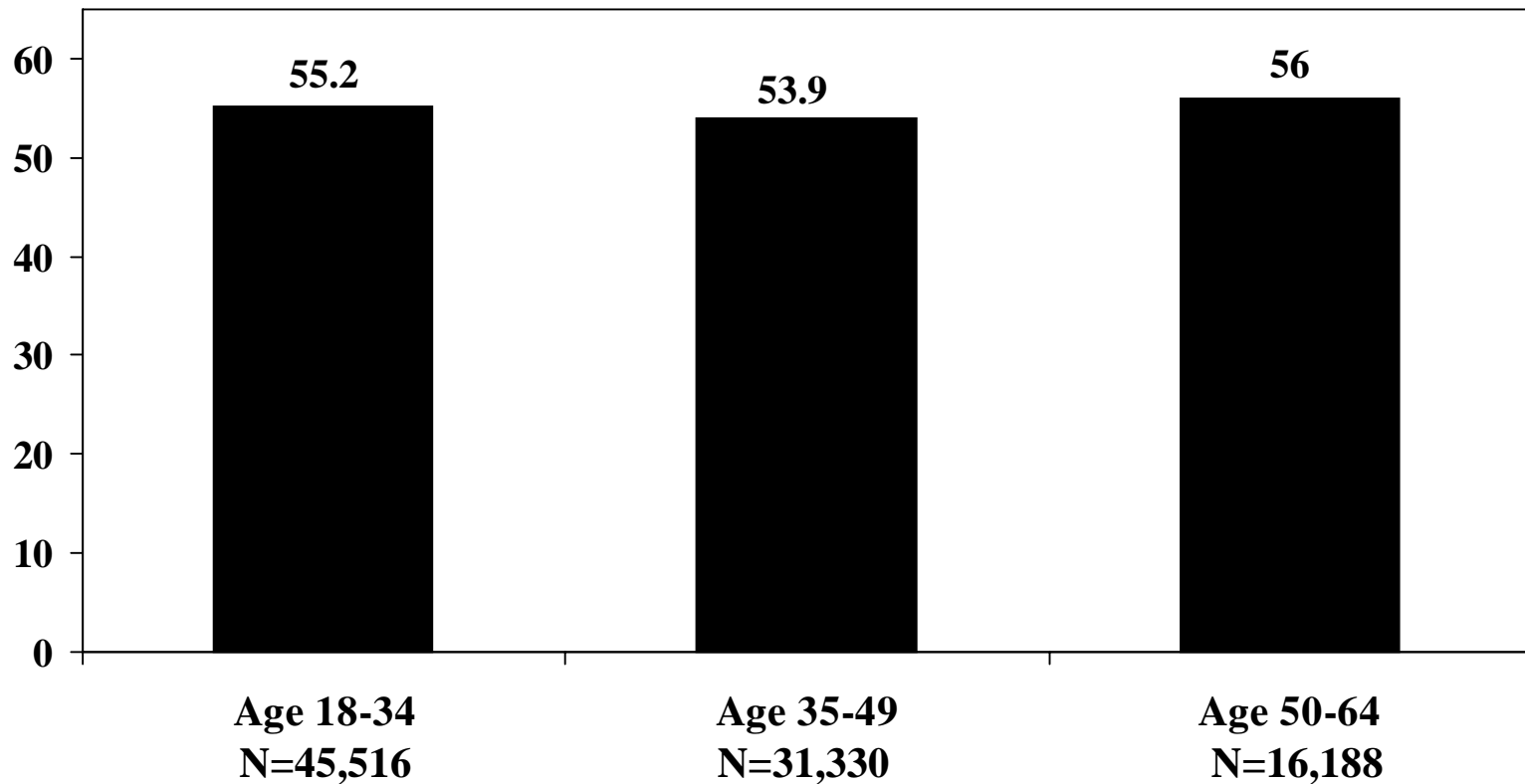
Over one-third in each of the age groups reported that they did not see a doctor in the past 12 months. The rate was highest for the 18-34 year old group (about 44%), but it is only a little higher than for the other two age groups (38% and 37% for the middle and older groups, respectively).

3-2. Percent of uninsured Rhode Islanders (18-64) who did not see a doctor in past 12 months: *the younger group is most likely to report not having seen a doctor in the past 12 months*



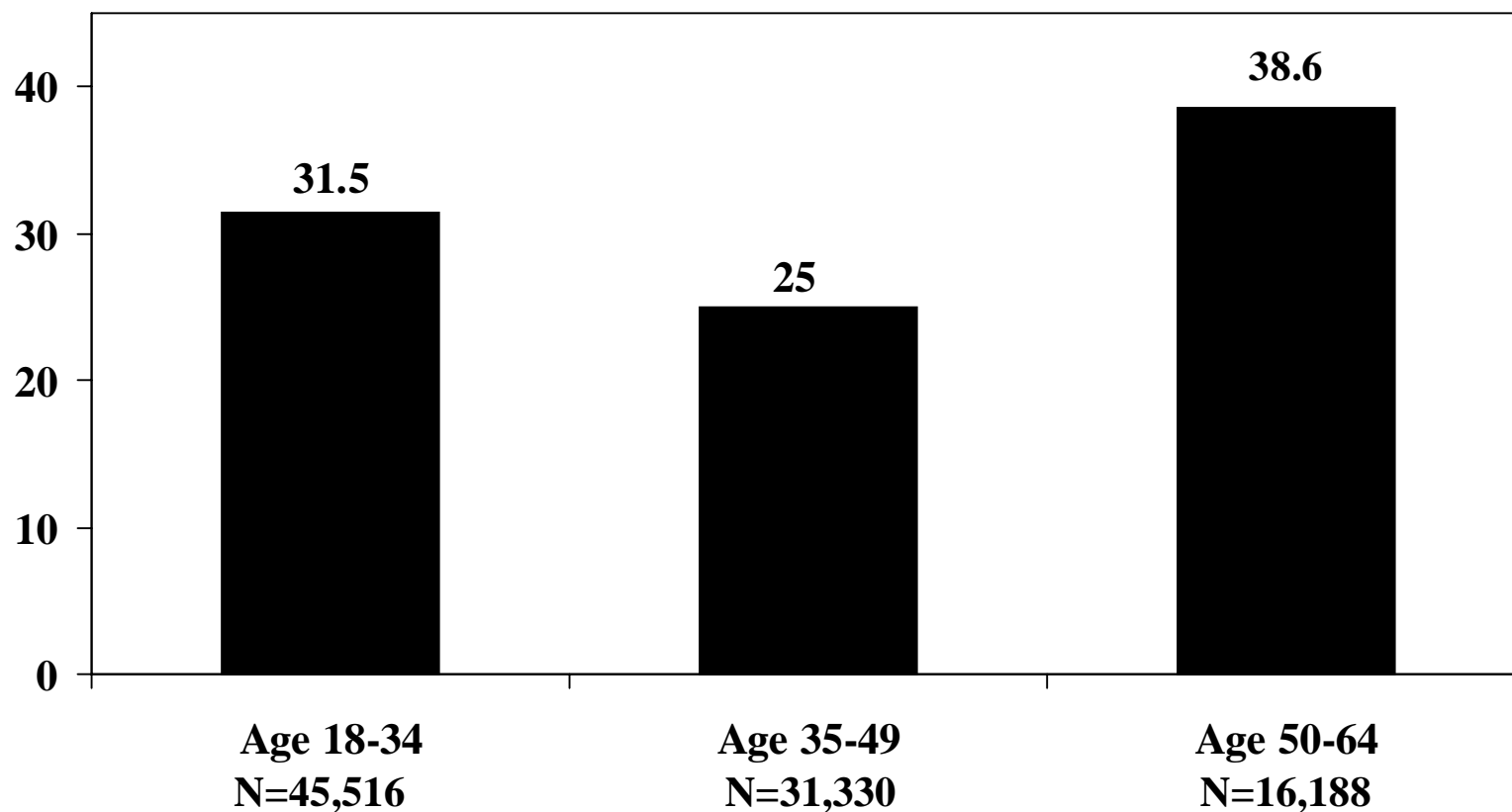
Over half in each of the uninsured age groups reported that they did not have a routine doctor visit in the past 12 months. There are no differences among the three age groups.

3-3. Percent of uninsured Rhode Islanders (18-64) who did not have a routine doctor visit in past 12 months: *there are no differences among the age groups – over half of each group reports no routine doctor visit in the past 12 months*



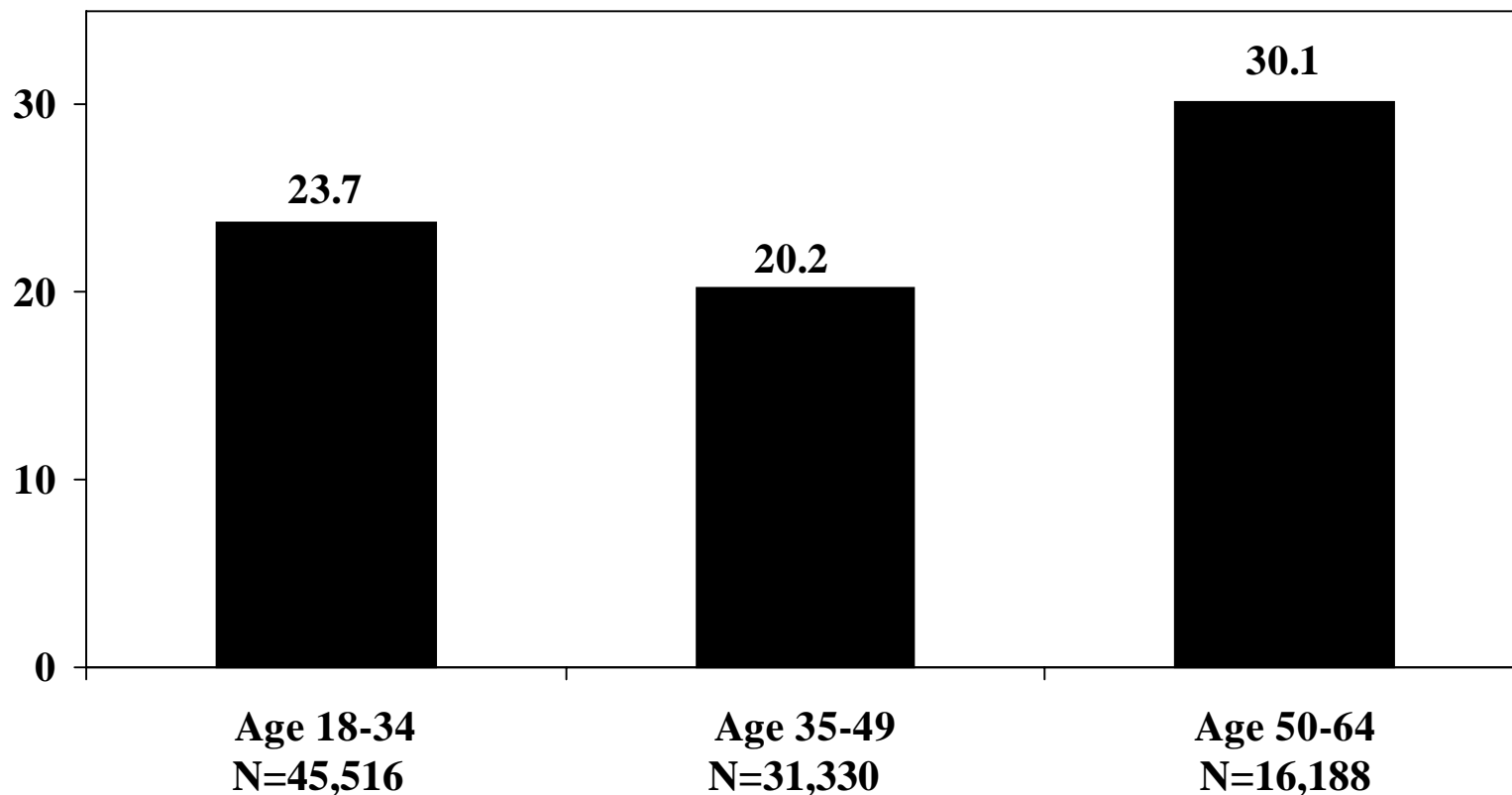
The older uninsured group, age 50-64, was the most likely to report not seeing a doctor due to cost in the past 12 months (about 39%). The middle age group, age 35-49, was the least likely at 25%, and the younger group was in between at about 32%.

3-4. Percent of uninsured Rhode Islanders (18-64) who did not get medical care from a doctor due to cost in past 12 months: *the older group was most likely to report not seeing a doctor due to cost*



The older uninsured group, age 50-64, was the most likely to report not getting a prescription due to cost in the past 12 months (about 30%). The middle age group, age 35-49, was the least likely at 20%, and the younger group was in between at about 24%.

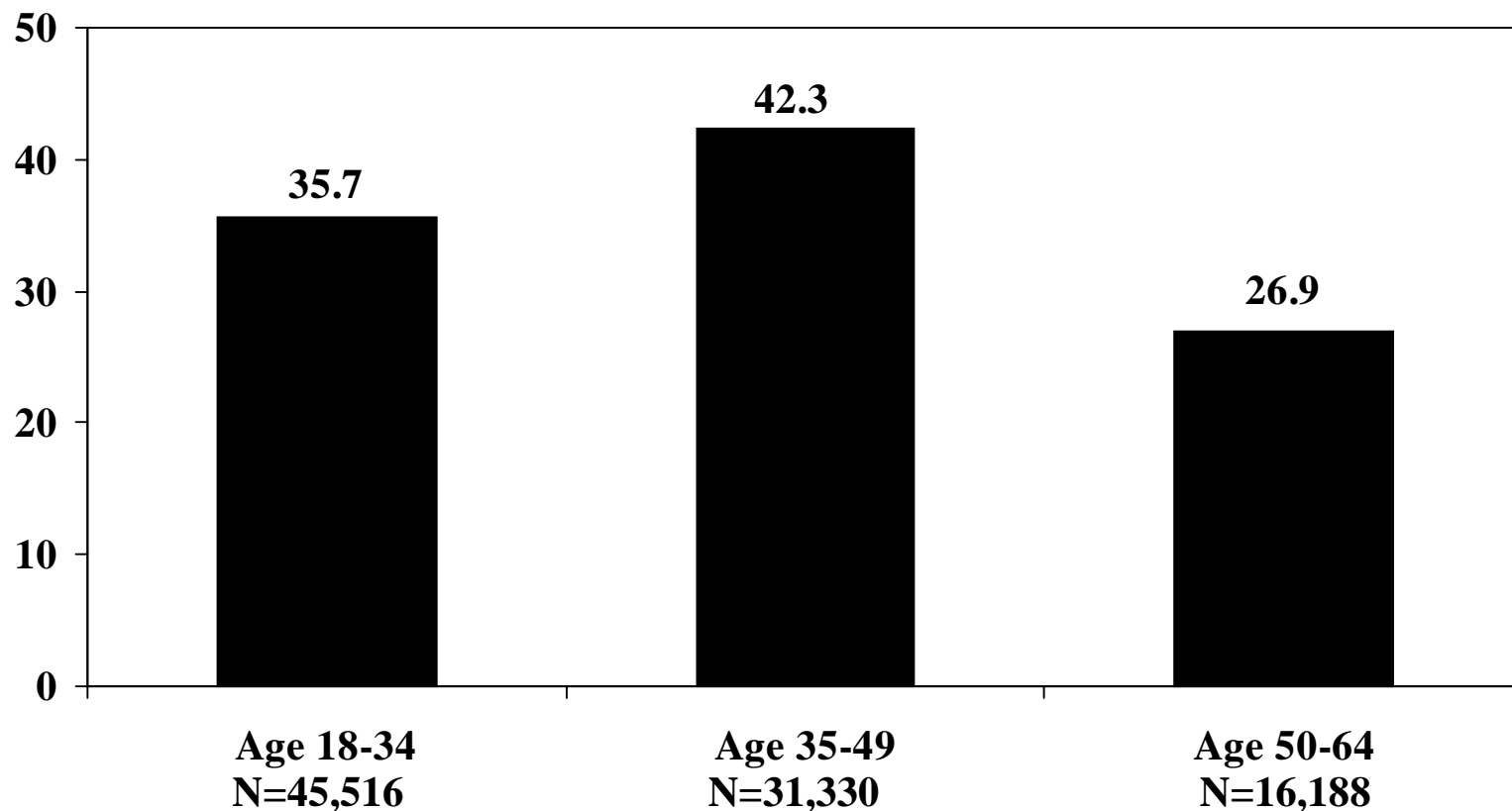
3-5. Percent of uninsured Rhode Islanders (18-64) who did not get a prescription due to cost in past 12 months: *the oldest group was most likely to report missing a prescription due to cost*



Section 4. Lifestyle

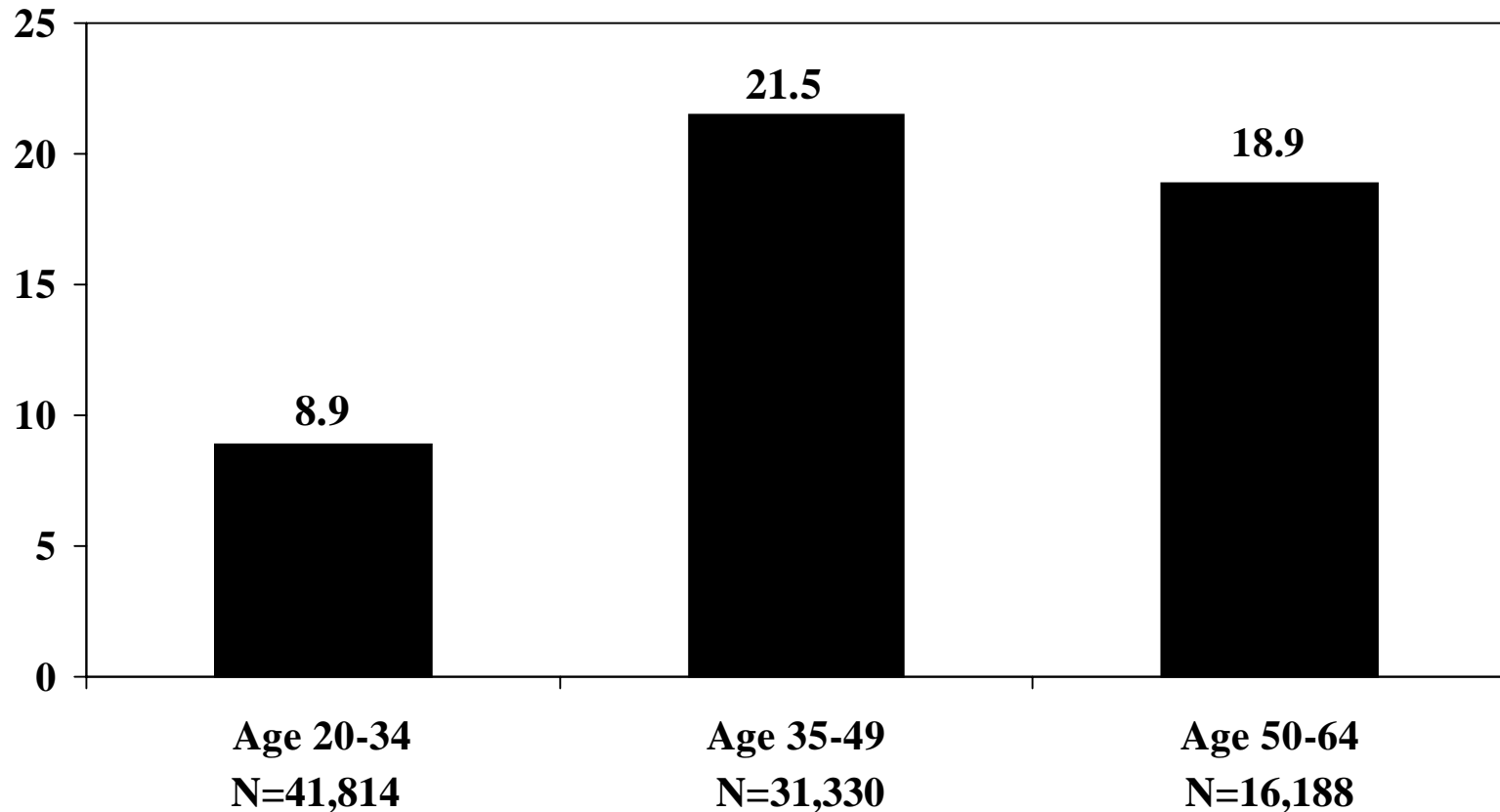
The middle age uninsured group, age 35-49, was the most likely to report smoking (about 42%). The older age group, age 50-64, was the least likely at 27%, and the younger group was in between at about 36%.

4-1. Percent of uninsured Rhode Islanders (18-64) who currently smoke: *the range of smoking is from about 4 in 10 for the middle group down to about a quarter for the older group*



The younger age uninsured group, age 18-34, had the lowest obesity rate at a little under one in ten (about 9%), while the two older groups had rates closer to one in five (about 22% and about 19% for 35-49 year olds and 50-64 year olds, respectively).

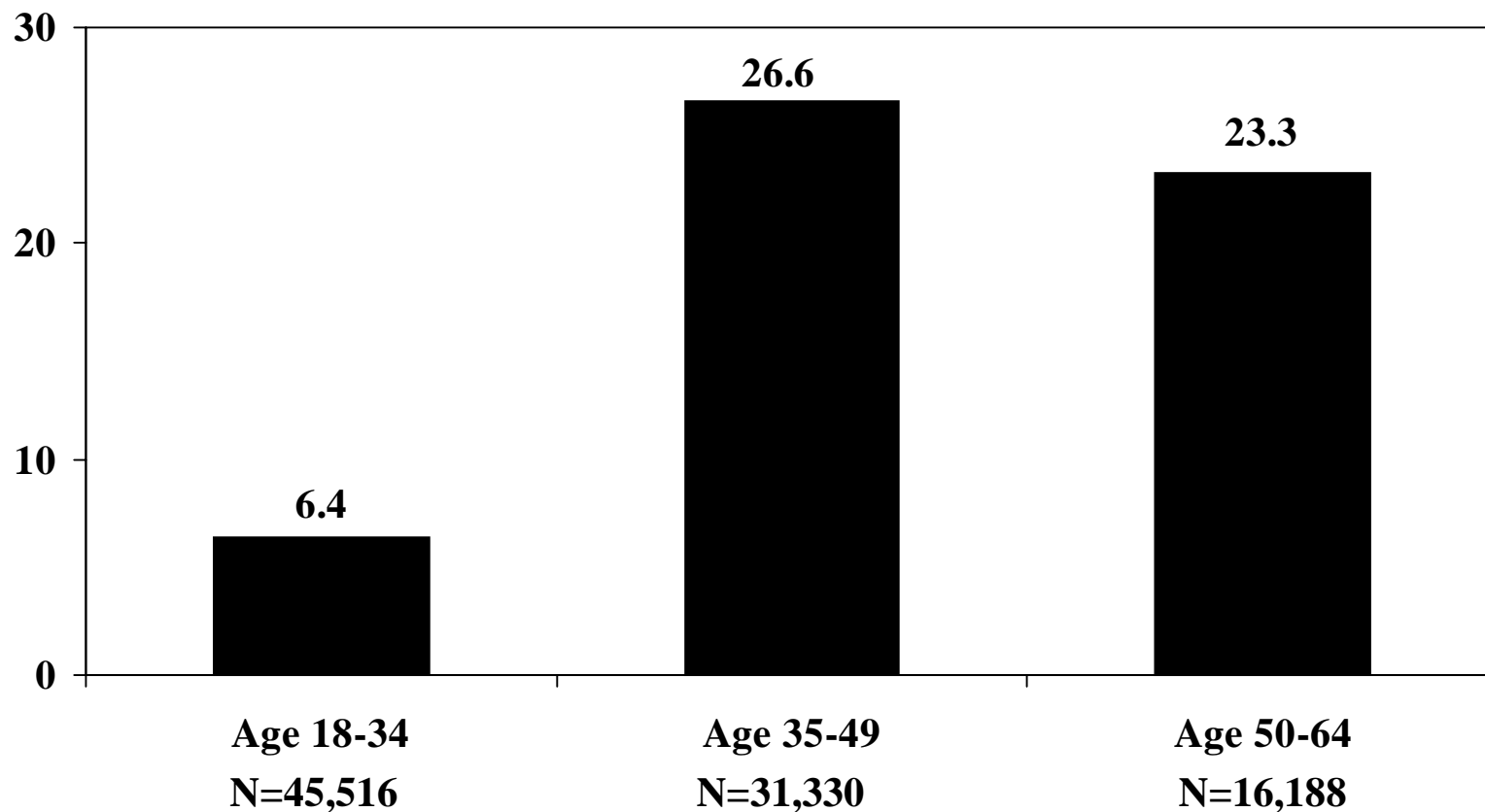
4-2. Percent of uninsured Rhode Islanders (20-64) who are obese: *the two older groups show the highest obesity rates (based on BMI), at nearly 1 in 5*



Section 5: Health Status

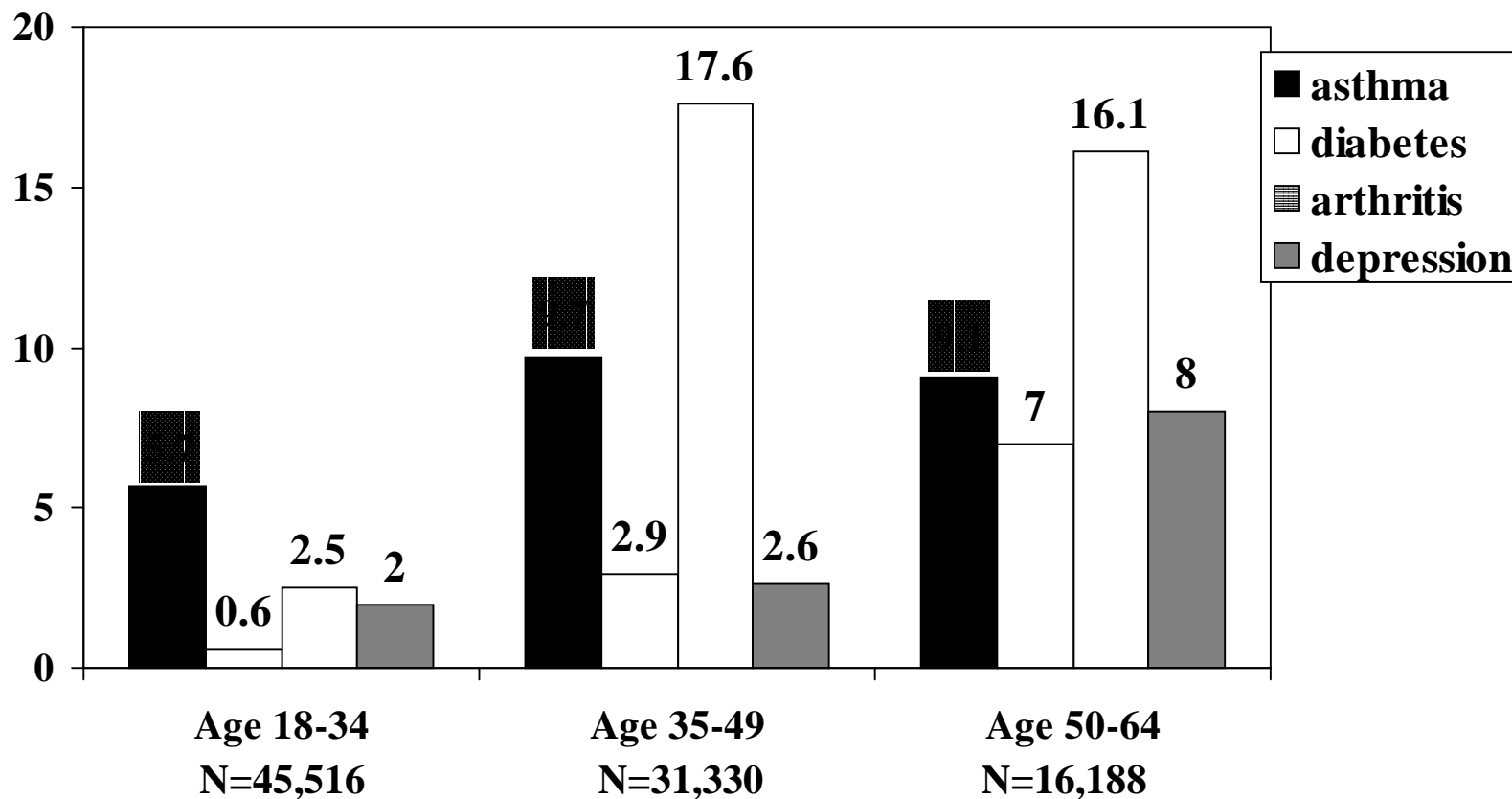
The younger age uninsured group, age 18-34, had the lowest ratings of fair or poor health at about 6%, while the two older groups had rates closer to one fourth (about 27% and about 23% for 35-49 year olds and 50-64 year olds, respectively).

5-1. Percent of uninsured Rhode Islanders (18-64) who rate their overall health as fair or poor: *nearly one-fourth of the uninsured in the two older groups rate their overall health as fair or poor*



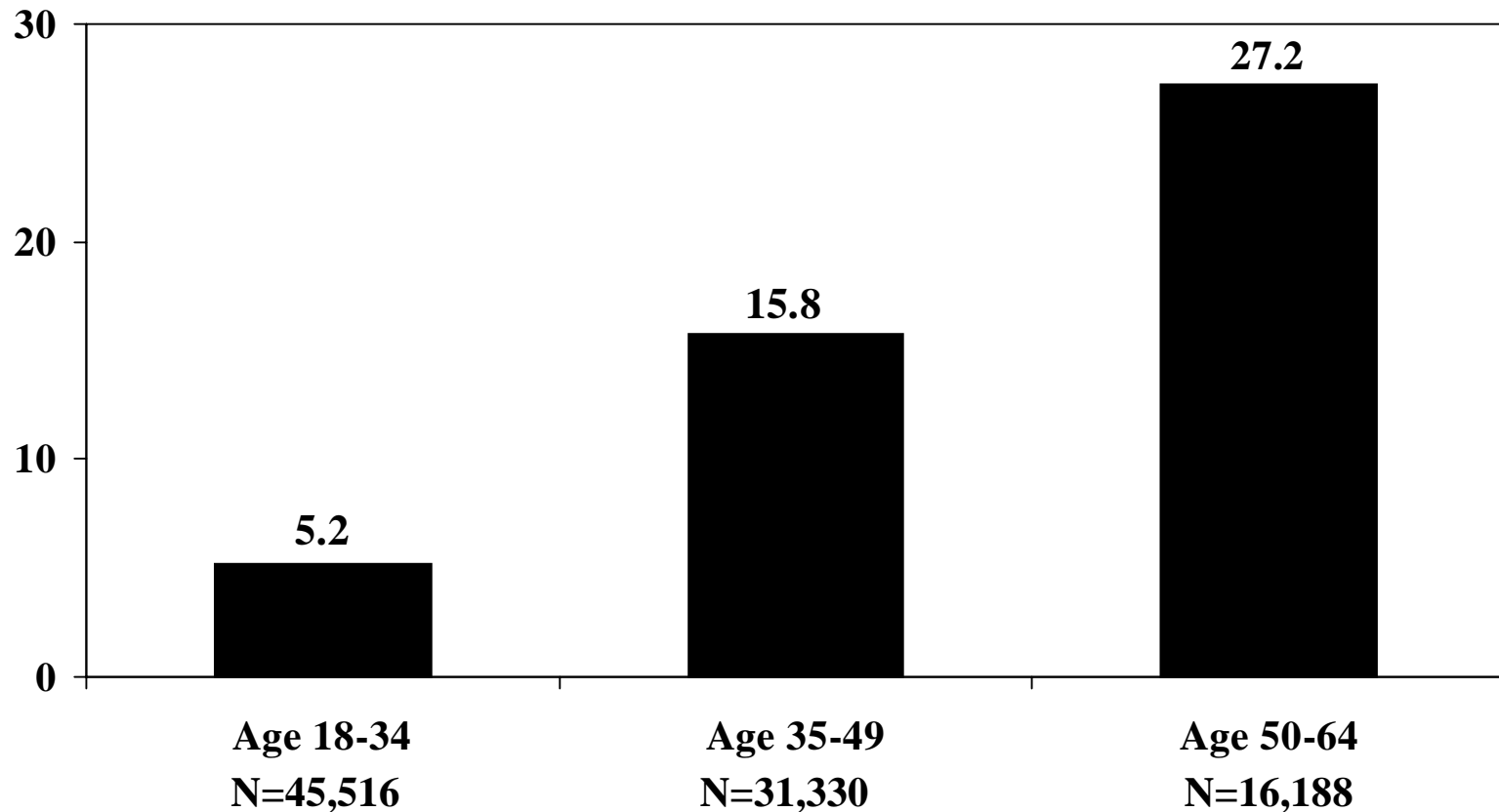
The younger age uninsured group, age 18-34, had the lowest reports of all four diseases shown here. The two older groups look very similar on reports of asthma and arthritis fair, but the group of 50-64 year old uninsured have the highest reports of diabetes and depression.

5-2. Percent of uninsured Rhode Islanders (18-64) reporting various health conditions: *the uninsured in the two older groups typically report more of the four diseases than those in the younger group*



Age clearly matters in reports of disability among the uninsured, with a step-wise increase in disability with age, from about 5% for the younger age group (age 18-34) to about 16% for the middle group (age 35-49) to over one-fourth (27%) for the older group (age 50-64).

5-3. Percent of uninsured Rhode Islanders (18-64) who report being disabled: *reports of disability increase with age, with over one-fourth of the older group reporting a disability*



medicaid and the uninsured

October 2005

PREMIUM ASSISTANCE PROGRAMS: HOW ARE THEY FINANCED AND DO STATES SAVE MONEY?

By Joan Alker

EXECUTIVE SUMMARY

Recently, there has been increased interest in using premium assistance programs to encourage low-income families' participation in private coverage, shore-up the private coverage market and prevent crowd-out, and achieve cost savings by bringing in employer contributions to help offset costs. Premium assistance programs use federal and state Medicaid and/or State Children's Health Insurance Program (SCHIP) funds to subsidize the purchase of private health insurance. They may also utilize employer or enrollee contributions to help pay premium costs. The increased interest in premium assistance has partly stemmed from the Administration's 2001 Health Insurance Flexibility and Accountability (HIFA) section 1115 waiver initiative, which encouraged states to implement premium assistance programs and relaxed certain benefit, cost sharing, and cost-effectiveness requirements.

A number of states have taken advantage of waiver flexibility to implement their premium assistance programs. How these programs are structured and whether they result in savings for states are considerations in assessing the impact of these programs. This brief examines premium assistance programs implemented under section 1115 waivers in five states (Illinois, New Jersey, Oregon, Rhode Island, Utah) to determine how they are financed; their eligibility, benefit, and cost sharing requirements; their methods for determining cost-effectiveness; and cost savings. Key findings include:

Financing. The examined states are using a variety of combinations of employer and enrollee contributions and subsidies to finance their premium assistance programs. Most are relying on employer contributions to help offset costs, and they all require individual contributions from at least some families (Table 1). Illinois and Utah cap their subsidy amounts, shifting the risk of remaining premium costs to enrollees, while New Jersey, Oregon, and Rhode Island pay premium amounts remaining after employer and fixed individual contributions.

Benefit and Cost Sharing Standards. The examined states also vary in their benefit and cost sharing standards. New Jersey and Rhode Island provide "wraparound coverage," meaning that they cover Medicaid benefits that are not covered by a private plan and any cost sharing in a private plan that exceeds the amounts allowed in Medicaid. In contrast, Utah and Illinois have very limited benefit and cost sharing requirements. Oregon requires that subsidized coverage meet a minimum benchmark that is actuarially equivalent to federally mandated Medicaid benefits.

Cost Effectiveness and Savings. The examined states use several different approaches to determine cost-effectiveness, including assessing whether an employer contribution is sufficient to ensure cost-effectiveness on a case-by-case basis (New Jersey and Rhode Island), capping

subsidy amounts (Illinois and Utah), and assessing aggregate program savings (Oregon). Among the examined states, there is limited data available regarding cost savings, but it is evident that Rhode Island and New Jersey are saving money on a per enrollee basis. However, in order to achieve overall savings, enrollment must be robust enough to generate sufficient savings to cover start-up and ongoing administrative expenses.

**Table 1:
Key Features of Premium Assistance Programs, Selected States, 2005**

	Required Employer Contribution?	Enrollee Contribution ^a	Capped Subsidy?	Wrap-around?	Savings Data ^b	Enrollment
Illinois	No	Amount remaining after subsidy/ employer contribution	Yes	No	None available	5,500
New Jersey	Yes	<150% FPL: None >150% FPL: Fixed amount	No	Yes	\$203.97 per family per month (varies from month to month)	729
Oregon	No	Fixed amount/proportion	No	No ^c	None available	10,564
Rhode Island	Yes	<150% FPL: None >150% FPL: Fixed amount	No	Yes	Average of \$222.45 per family per month (including administrative costs)	6,012
Utah	Yes ^d	Amount remaining after subsidy/ employer contribution	Yes	No	Subsidy is \$50 per member per month, compared to \$80 per member per month for direct coverage	73

^a Employer contributions are often present even if they are not required.

^b All savings data represent combined federal/state savings.

^c Oregon requires subsidized coverage to meet a minimum benchmark that is actuarially equivalent to federally required Medicaid benefits.

^d Industry practice in Utah requires a 50% employer contribution.

Taken together, the findings suggest the following:

Two key elements for achieving savings are an employer contribution and robust enrollment. An employer contribution offsets federal, state, and individual costs. In addition, enrollment must be high enough to generate sufficient savings to cover start-up and ongoing administrative expenses. To date, enrollment in premium assistance programs has been relatively low, likely reflecting the limited availability of employer-sponsored coverage among low-income workers and affordability problems for some individuals.

States can achieve savings without capping their subsidy amounts, and while still providing wraparound coverage. Rhode Island and New Jersey, which have documented program savings, provide wraparound coverage and do not cap their subsidy amounts. In the other examined states, coverage is not required to meet Medicaid benefit and cost-sharing standards, but it is not clear that these states are saving money.

Changes in the private market impact the cost-effectiveness of premium assistance programs. Recently, there have been sharp increases in private coverage premiums, and private market costs have been increasing more rapidly than Medicaid on a per-capita basis. If private premiums continue to increase faster than Medicaid, and workers are asked to share a larger percentage of the growing cost, the calculation of whether it is cost-effective for states to buy families into private coverage becomes less and less favorable. States can limit their costs by capping their subsidies, but this shifts the risk of added costs to enrollees.

INTRODUCTION

Premium assistance programs use federal and state Medicaid and State Children's Health Insurance Programs (SCHIP) funds to subsidize the purchase of private health insurance coverage. The recent emphasis on premium assistance programs in the Administration's 2001 Health Insurance Flexibility and Accountability (HIFA)¹ waiver initiative and tough state fiscal climates have combined to provoke increased interest in this approach. Some states are now pursuing this approach as a way to encourage low-income families' participation in private coverage, shore-up the private coverage market, and achieve cost savings by bringing in employer contributions to help offset costs. Some also believe this approach helps prevent "crowd out" of private coverage by providing a public/private blend of coverage to individuals at the upper end of the low-income spectrum. Yet, recent sharp increases in the cost of private coverage along with new federal guidelines permitting states to require low-income families to shoulder more costs raise questions about the efficacy of this approach.

How premium assistance programs are structured and whether they result in savings for states are considerations in assessing the impact of these programs. This brief examines premium assistance programs implemented under section 1115 waivers in five states (Illinois, New Jersey, Oregon, Rhode Island, Utah) to determine how they are financed; their eligibility, benefit, and cost sharing requirements; their methods for determining cost-effectiveness; and cost savings.

BACKGROUND

What are the federal requirements for premium assistance programs?

Under current Medicaid law, states have the option of subsidizing the purchase of private group health plans for Medicaid beneficiaries if it is cost-effective to do so. States can also pay premiums for non-Medicaid eligible family members if it is cost-effective to do so and may make enrollment in a group health plan a requirement of Medicaid eligibility. Cost-effective is defined by statute to mean that the reduction in expenditures for an individual enrolled in a group health plan is likely to be greater than the additional cost of paying premiums and cost sharing for these same individuals.²

States that develop premium assistance programs without a waiver must ensure that beneficiaries that enroll in private coverage retain access to all benefits covered under the state's Medicaid program and are protected from costs in excess of amounts allowed in Medicaid. In other words, states must provide "wraparound coverage" for Medicaid benefits that are not covered by the private plan and for excess cost sharing. Federal Medicaid law limits the levels of cost sharing that may be imposed on children and their parents, and premiums are not permitted.³ Children may not be charged any cost sharing and parents can be charged "nominal" amounts.

¹ Centers for Medicare and Medicaid Services, "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: <http://www.cms.hhs.gov/hifa/hifagde.asp>. For an overview of states' response to the premium assistance component of HIFA, see Alker J. *Premium Assistance: A Look at Recent State Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), November 2003.

² §1906 (3)(e)(2) of the Social Security Act.

³ For a good summary of Medicaid cost sharing rules, see Chapter 2 of *The Medicaid Resource Book* by Andy Schneider (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), July 2002. Some states have

States can also develop premium assistance programs using SCHIP funding. For states seeking to use SCHIP funds for premium assistance, federal regulations require that “The State’s cost for coverage for children under premium assistance programs *must not be greater than* the cost of other SCHIP coverage for these children.”⁴ States also must provide wraparound coverage for benefits and limit cost sharing for families enrolled in SCHIP-funded premium assistance programs if there is no federal waiver.

What kinds of changes in premium assistance do waivers allow?

Section 1115 waivers give states authority to use federal Medicaid and SCHIP funds in ways not otherwise permitted under current law. The federal government’s 2001 HIFA initiative encouraged states to seek waivers that included premium assistance components and loosened certain requirements for premium assistance programs.

Under waivers, the federal government has permitted some states to enroll beneficiaries in premium assistance programs without providing wraparound coverage for benefits or cost sharing. HIFA guidance and CMS policy for families participating in premium assistance programs whose income exceeds “mandatory” Medicaid categories allows waivers with no benefit requirements and no limits on the cost sharing that families may be required to pay.⁵ No state has yet sought a waiver of cost sharing rules for a premium assistance program to serve mandatory Medicaid children.

Federal HIFA guidelines also relaxed the cost-effectiveness requirements. Under the HIFA guidelines, “States should monitor that aggregate costs for those enrolled in premium assistance programs are not significantly higher than costs would be if under a direct coverage program...”⁶

What kind of private coverage is available for low-wage workers?

Premium assistance programs primarily, but not exclusively, subsidize employer-sponsored insurance.⁷ However, in general, low-income workers have limited access to employer-sponsored coverage (Figure 1). As Figure 1 shows, low-income workers also are less likely to participate in employer-sponsored insurance when it is offered, but the differences by income level are not large. Recent sharp increases in premiums have likely had a disproportionate impact on low-wage workers’ ability to participate. From 2003-2004, premiums rose by 11.2%,⁸ and the average worker’s monthly contribution for family coverage was \$222, a very substantial proportion of a low-wage worker’s take-home pay. In addition, the smaller the firm the higher

sought and received Section 1115 waivers of some federal cost sharing rules – most commonly for adults but in some cases for higher-income Medicaid-eligible children. Subsequently a number of these waivers have been successfully challenged in court; thus policy is evolving in this area.

⁴ See 42 CFR Part §457.810(c)(1); January 11, 2001.

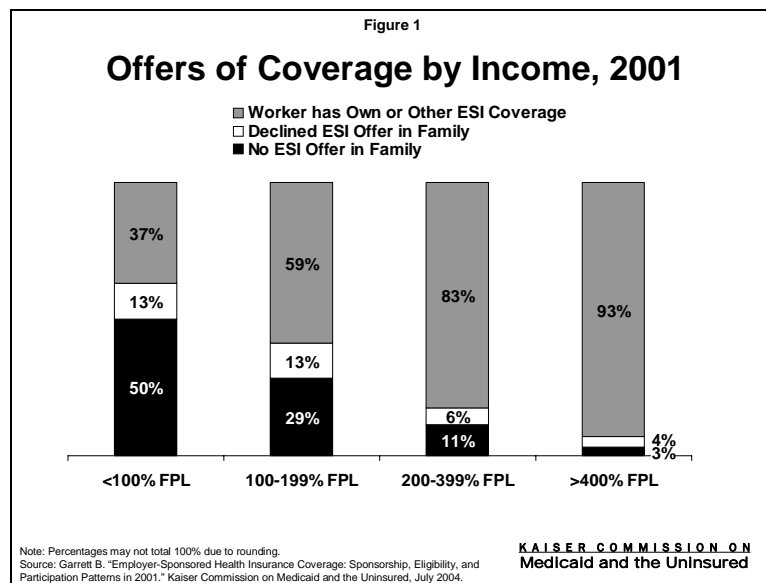
⁵ See Alker, J. op cit.

⁶ “Guidelines for States Interested in Applying for a HIFA Demonstration,” p 5.

⁷ Exceptions to this include Oregon, Massachusetts, and Illinois.

⁸ *Kaiser/HRET Employer Health Benefits: 2004 Summary of Benefits*. (Washington, DC: Kaiser Commission on Medicaid), September 2004.

the worker's contribution is likely to be.⁹ These increases in worker contributions have been accompanied by increases in other forms of employee cost sharing. Deductibles, cost sharing and coinsurance have all been on the rise.¹⁰



FINDINGS

This analysis examines premium assistance programs in five states (Illinois, New Jersey, Oregon, Rhode Island, and Utah) to assess how these programs are financed, their eligibility and coverage requirements, the states' methods for determining cost-effectiveness, and whether the programs have achieved cost savings. All five programs were implemented under Section 1115 waiver authority, but they reflect different state choices on issues such as employer contributions, participant cost sharing, and subsidy levels. In addition, Iowa's Health Insurance Premium Payment (HIPP) program, which operates under existing Medicaid law without waiver authority, was included for comparative purposes.

How are the Program Costs Shared?

There are three potential sources of funding for premium assistance programs:

- 1) federal/state Medicaid and/or SCHIP dollars;
- 2) employer contributions; and
- 3) premium contributions made by families.

Table 2 provides an overview of how the programs in the study states are financed. All of the states utilize federal and state Medicaid and/or SCHIP dollars. States vary, however, with respect to the mix and level of employer and individual contributions. Illinois and Utah cap subsidy amounts regardless of the cost of purchased coverage, shifting the risk of added costs to

⁹ Gabel JR and Pickreign JD. *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York, NY: The Commonwealth Fund), April 2004.

¹⁰ Kaiser/HRET *Employer Health Benefits: 2004 Summary of Benefits*.

enrollees. New Jersey, Oregon, and Rhode Island pay amounts remaining after employer and individual contributions. Thus, the subsidies vary across families and are driven by the cost of coverage as well as individual and employer contribution amounts. In the comparison program in Iowa, the state covers the entire premium cost after any employer contribution is made.

Table 2:
Distribution of Premium Costs in Premium Assistance Programs, Selected States, 2005

	State/Federal Subsidy			Employer* Contribution Required?	Individual Contribution		
	Full Premium Amount	Capped Monthly Subsidy	Amount Remaining After Employer/ Individual Contributions		None	Fixed amount or proportion	Any Amount Remaining After Subsidy and Employer Contribution
<i>Iowa (comparison program)</i>	✓		✓	✓**	✓		
Illinois		✓		X			✓
New Jersey			✓	✓	✓ (<150% FPL)	✓ (>150% FPL)	
Oregon			✓	X		✓	
Rhode Island			✓	✓	✓ (<150% FPL)	✓ (>150% FPL)	
Utah		✓		✓***			✓

Sources: see Appendix A

* Employer contributions are often present even if they are not required.

** In order to prove cost effectiveness, an employer contribution is almost always required.

*** Industry practice in Utah requires a 50% employer contribution

Three of the five waiver programs (New Jersey, Rhode Island, and Utah) require an employer contribution, although the level required varies across these states. Illinois and Oregon do not require a contribution but they are common. In Oregon, if an employer offers coverage with a contribution, the premium assistance enrollee must enroll in that plan.

The role of the employer contribution: The New Jersey experience

Given that private insurance is typically more expensive than Medicaid coverage for similarly situated families, an employer contribution is often essential to ensuring that premium assistance programs are cost-effective. There are minimal federal requirements with respect to the presence or level of an employer contribution, so this area is largely one of state decision.

The best available information from the states examined comes from New Jersey where the state requires a minimum employer contribution of 50% for a family to be considered for a premium assistance subsidy. Two-thirds of employers participating in the program, however, pay 70% or more of premium costs. New Jersey's program administrator believes that the state could boost enrollment in its program by approximately 10% if the minimum employer contribution was lowered to 30%. Below that, the state believes that it will always be cheaper to keep families in Medicaid. The state's experience suggests that, in most cases, a significant employer contribution is needed to ensure cost-effectiveness, but there are some exceptions. These exceptions might be related to larger family size or high service use.

All five waiver programs require at least some enrollees to cover part of the cost of their premiums. New Jersey and Rhode Island require families at the upper end of income eligibility to pay a fixed share of the premium; lower income families are not required to pay. In Oregon, families pay a proportion of the overall premium cost that ranges from 5%-50%--the proportion is based on a family's income. However, there is no upper limit on the amount of the family's share. In Illinois and Utah, families must pay the share of the premium remaining after the employer's contribution and the state's fixed subsidy. Thus, the amounts families pay vary based on the cost of their coverage and their employer contributions with no upper limit. In Iowa's comparison program, families are not required to contribute anything, because the Medicaid subsidy covers the full premium cost after any employer contributions.

**What kind of employer-sponsored coverage is being subsidized with Medicaid and SCHIP funds?
A look at Walmart**

Walmart is the world's largest corporation, the largest private sector employer in the United States, and the country's largest low-wage employer. Walmart offers health coverage to employees who have been employed for at least six months and work at least 34 hours a week. Those who are offered coverage must pay a share of premiums as well as their plan's deductible and other cost sharing requirements.

A Walmart sales associate who is employed 40 hours a week making \$7/hour earns less than \$15,000 per year or about \$1,200 per month.¹¹ In 2004, the employee premium share for a Walmart-offered plan with a \$350 deductible that covers the associate and one child (but no spouse) was \$181 per month, representing about 15% of the worker's monthly pre-tax income.¹² The employee share was \$250 for full family coverage, constituting about 21% of the worker's pre-tax income.

New Jersey, which determines the cost-effectiveness of subsidizing private coverage by assessing the adequacy of the employer contribution and provides wraparound coverage protections, has concluded that it is never cost effective to subsidize Walmart's coverage because of the high out-of-pocket costs.¹³

However, a state like Illinois, which provides a capped subsidy and has limited requirements for subsidized coverage, would likely subsidize Walmart's coverage. Illinois provides a maximum subsidy of \$75 per child per month, which would reduce the premium costs for the worker and child to \$106 per month. After receiving the subsidy, premium costs still constitute almost 9% of the worker's pre-tax income.¹⁴ And, before receiving any benefits from the plan, the worker would need to pay a \$350 deductible, another 2% of the worker's annual pre-tax income.

Who is Eligible and Who is Enrolled?

Table 3 provides an overview of the eligibility requirements and characteristics of enrollees for premium assistance programs. The examined programs cover both children and their parents, with the exception of Utah where children are not eligible. A number of the programs offer

¹¹ Based on Olivio A. *Walmart wages grass-roots campaign to crack Chicago*. The Chicago Tribune, May 23, 2004.

¹² Center for Children and Families analysis based on information from *MyBenefits WalMart Stores, Inc 2004 Associate Guide* and *WalMart Open Enrollment News* September 2003. Premium costs used for the Network Saver Associate Child and Network Saver Family coverage option.

¹³ Phone Interview with Dennis Doderer, Deputy Assistant Director, New Jersey Division of Medical Assistance and Health Services 4/14/04.

¹⁴ Center for Children and Families. A good comparison to bear in mind is that federal tax law considers health care expenses in excess of 7.5% of a family's adjusted gross income to be deductible for income tax purposes.

coverage to people at very low-incomes, yet as Table 3 shows, in every state examined, enrollees tend to cluster in the higher income ranges even when they are eligible at lower income levels. This likely reflects the fact that availability of employer-sponsored coverage diminishes as income level decreases.

Table 3:
Eligibility and Enrollment in Premium Assistance Programs, Selected States, 2005

State	Who is Eligible?	Participation Mandatory?	Enrollment	Income Breakdown of Participants	
Iowa (Comparison program)	Children <133% FPL Pregnant women <200% FPL Parents <84% FPL	Yes, if have access to cost-effective ESI	9,342	Not available, all enrolled are below Medicaid eligibility	
Illinois	Children 133-200% FPL*	No	5,500	133-150% FPL	29%
				150-200% FPL	71%
New Jersey	Children <350% FPL Parents <200% FPL	Yes, if have access to cost-effective ESI	729	<150% FPL	22%
				150-200% FPL	73%**
Oregon	Children <185% FPL Pregnant women <185% FPL Parents & other adults <185% FPL	Yes for parents and other adults with access to state-approved ESI	10,564	<100% FPL	38%
				101-185% FPL	62%
Rhode Island	Children <250% FPL Pregnant women <250% FPL Parents <185% FPL	Yes, if have access to state-approved ESI	6,012	<100% FPL	20%
				100-150% FPL	44%
				150-250% FPL ***	36%
Utah	Parents & other adults 50-150% FPL Must be uninsured for >6 months and have ESI premium that is >5% of income	Yes, unless premium for ESI is >15% of income	73	0-100% FPL	41%
				101-150% FPL	49%

Sources: see Appendix A

Note: ESI Employer Sponsored Insurance

* The state is currently phasing-in an expansion of parent eligibility. When parents in this income range become eligible, they will also have the option to enroll in KidCare Rebate.

**5% at >200% FPL

***Some eligible beneficiaries may be over 250% FPL because of Transitional Medical Assistance

In Illinois, eligible individuals can choose between receiving premium assistance or direct coverage. In New Jersey, Oregon, and Rhode Island, as well as in the comparison program in Iowa, eligible individuals must enroll in premium assistance rather than receive direct coverage if they have access to cost-effective employer-sponsored insurance. In Utah, eligible individuals with access to employer-sponsored insurance must enroll in premium assistance unless the premium for such insurance exceeds 15% of their income. If their premiums exceed this amount, eligible individuals can choose between direct coverage or premium assistance.

Nationwide, enrollment in premium assistance programs has generally been low—a recent study found that, with one exception, enrollment constituted less than one percent of the relevant eligibility groups in Medicaid and SCHIP.¹⁵ This trend generally holds true within the examined states, except for Rhode Island, which has seen considerable growth in its program.

¹⁵ See Alker, J. op cit.

What are the Requirements for Subsidized Coverage?

As noted, when states implement premium assistance programs without a waiver, they must ensure that enrollees do not have more limited benefits or higher premiums and cost sharing than the state's regular Medicaid program. However, under waivers, some states have been allowed to subsidize the purchase of private coverage without providing wraparound coverage. Within these programs families may have more limited benefits and higher cost obligations.

As Table 4 illustrates, the examined states have widely varying requirements with respect to benefits, premiums, and other cost sharing obligations. The waiver programs in New Jersey and Rhode Island, as well as the comparison program in Iowa, provide wraparound coverage to ensure that families have the same benefits and are subject to the same cost sharing rules as families in their direct Medicaid coverage. Regular Medicaid rules apply in Iowa where children pay no cost sharing and adults are subject to nominal copays. In New Jersey and Rhode Island, families under 150 percent of the poverty level do not pay any premiums or cost sharing. Above 150 percent of the poverty level, families are subject to the same premium and cost sharing requirements as families in the states' direct Medicaid coverage, which operates under a waiver that allows premiums to be charged. Interestingly, Rhode Island's experience has been that the vast majority of the state's expenditures – 93 percent – has been for the premium subsidy and the remaining seven percent for the cost of wraparound coverage.¹⁶

Utah and Illinois do not provide wraparound coverage and have minimal benefit and cost sharing requirements for subsidized coverage. As such, enrollees in Utah and Illinois pay all copayments, coinsurance and deductibles required by the private insurance plan with no out-of-pocket limit and any additional premium costs not covered by the state's subsidy. In addition, Utah requires an upfront \$50 enrollment fee and the state's maximum premium subsidy of \$50 per month is scheduled to decline over time if participants remain enrolled in the program.

Oregon uses an overall actuarial test to assess whether subsidized coverage meets a minimum benchmark equivalent to federally mandated Medicaid benefits. Families are not subject to an out-of-pocket cap, and the coverage, while meeting certain minimum standards, may not be as comprehensive as the state's own waiver coverage.

¹⁶ This is an average for the cost of supplemental benefits and premiums for state fiscal years 2001-2004. Data taken from RIteShare Summary of Payments March 2004 Financial Cycle provided by the RIteShare program, Rhode Island Department of Human Services. It is possible that some families are not aware of the availability of the wraparound services thus lowering their cost.

Table 4:
Benefits and Cost Sharing in Premium Assistance Programs, Selected States, 2005

State	State Provides Wraparound Coverage?	Required Benefits	Premiums and Cost Sharing Requirements
<i>Iowa (comparison program)</i>	✓	Full Medicaid benefits through wraparound	Same as state's direct Medicaid coverage through wraparound (State covers all premiums, deductibles, and coinsurance; No copays for children; Parents pay nominal copays)
Illinois	No	Plan must have inpatient/outpatient coverage	Beneficiaries pay additional premium costs not covered by subsidy and all cost sharing required by private plan
New Jersey	✓	Full Medicaid benefits through wraparound	Same as state's direct Medicaid coverage through wraparound: (<150% FPL: No premiums or cost sharing >150% FPL: fixed premiums and non-fixed copayments with a 5% cap on cost sharing)
Oregon	No	Plan must be actuarially equivalent to mandatory Medicaid benefits	Beneficiaries pay a share of premium, based on income, without a cap on the amount Subsidized coverage can have up to \$1,000 deductible, \$4,000 maximum out-of-pocket costs per individual, and \$10,000 stop loss provision
Rhode Island	✓	Full Medicaid benefits through wraparound	Same as state's direct Medicaid coverage through wraparound: (<150% FPL: no premiums or cost sharing >150% FPL: fixed premiums and copayments)
Utah	No	None	Beneficiaries pay additional premium costs not covered by subsidy and all cost sharing required by private plan

What Impact Does Cost Have on Enrollment and Access to Services?

Given that Medicaid beneficiaries have very limited incomes, cost obligations can have a significant impact on their ability to enroll in coverage. Existing research has documented that premiums can serve as an enrollment barrier for low-income families.¹⁷ As noted, many premium assistance programs have experienced low enrollment, and the premium contributions required from families may be a contributing factor, as discussed in the examples below.

Enrollment in Utah's "Covered at Work" premium assistance program has been extremely low—73 persons according to the most recent enrollment data.¹⁸ Utah program officials believe that the premium requirements as well as cost sharing obligations may be contributing to this low level of enrollment.¹⁹ Policymakers in Utah are considering raising the premium subsidy, which would reduce the burden on individuals, to encourage participation in the program.

Illinois' premium assistance program, "KidCare Rebate," has been in existence for some time—it was funded with state-only dollars prior to the state's Section 1115 waiver approval. In the past, families participating in this program were not eligible for the state's regular direct SCHIP

¹⁷ Artiga, S. and O'Malley, M. "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences" Kaiser Commission on Medicaid and the Uninsured, May 2005

¹⁸ Enrollment data from Utah "Covered at Work" as of 3/26/05.

¹⁹ Interview with Michael Hales, Director Utah Primary Care Network, April 13, 2004.

coverage, KidCare, because their children were insured. Therefore, receiving a \$75 subsidy from the state towards the cost of private insurance was a clear benefit for these families. At the time that federal approval was given to use federal dollars for the KidCare Rebate program, families were given the option to switch their children from KidCare Rebate to the regular KidCare program. According to state officials, approximately 1,200 children—or 20 percent—chose to do so. Monthly premiums for regular KidCare participants are \$15 for one child, \$25 for two children, and \$30 for three or more children.²⁰ These are likely to be lower than private insurance premium costs for many low-wage workers, even after receiving the state subsidy. It is possible that out-of-pocket costs contributed to these families' decision to switch programs, but no specific evidence is available.

Research has also shown that cost sharing can impede low-income individuals' ability to access necessary care.²¹ Cost sharing in private insurance plans can be substantially higher than the limited amounts allowed under Medicaid and SCHIP. This raises the question of whether families participating in programs such as Illinois and Utah with unlimited cost sharing are having trouble accessing needed care. Unfortunately, neither Illinois nor Utah has data or plans to seek data to answer this question. In addition, these states have little in the way of minimum benefit requirements.²² If families are purchasing private plans with limited benefits they may be experiencing difficulty accessing and/or affording care for uncovered services. To date, no data is available about what kind of coverage is being purchased in these states and what additional cost sharing low-income families are being asked to assume.

How Do the States Determine Cost-Effectiveness and are they Saving Money?

Table 5 provides an overview of the different methods the states examined use to determine cost-effectiveness for their premium assistance programs and the available data on cost savings. As seen in the table, the states generally used one of two savings approaches—achieving savings through employer contributions or achieving budget certainty by capping subsidy amounts. However, Oregon used its own approach, which focused on aggregate program savings.

²⁰ Illinois KidCare program website: http://www.kidcareillinois.com/sharing_kc.html

²¹ Artiga, S. and O'Malley M. op cit.

²² Illinois requires that subsidized policies have an inpatient and an outpatient benefit, but there are no requirements regarding the scope of benefits. Utah requires only that plans meet applicable state insurance laws.

Table 5:
Cost- Effectiveness Tests and Cost Savings in Premium Assistance Program, Selected States, 2005

	Method for Determining Cost-Effectiveness			Cost-Effectiveness Requirements	Data on Savings
	Assessing Level of Employer Contribution	Capping State Contribution	Assessing Aggregate Program Savings		
Iowa (comparison program)	✓			<i>Paying the ESI premium must save the state at least \$5 per month compared to the average cost of Medicaid</i>	<i>State believes it is saving an average of 30% per-beneficiary-per-month</i>
Illinois		✓		State's costs controlled by cap on subsidy amount. Amount based on average SCHIP pmpm costs in 1998	None available
New Jersey	✓			Subsidized coverage must realize both a 5% savings in coverage costs and a 5% savings in administrative costs	\$203.97 per family per month (this varies from month to month)
Oregon			✓	No specific savings requirements	None available
Rhode Island	✓			Monthly premium share plus the cost of wraparound coverage must be less than the capitation rate for the average Medicaid family	An average of \$222.45 per family per month (including administrative costs)
Utah		✓		State's costs controlled by cap on subsidy amount	Subsidy is \$50 pmpm, compared to \$80 pmpm for direct coverage*

PMPM: Per member per month

*\$80 pmpm represents costs of serving individuals through the state's Primary Care Network waiver program which covers primary care without coverage for hospital or specialty care.

Achieving savings through the use of employers' contributions: The waiver programs in New Jersey and Rhode Island, as well as the comparison program in Iowa, perform individualized determinations of cost-effectiveness, assessing whether an employer's contribution is adequate to save the state money. All three states provide families with "wraparound" coverage—ensuring that families retain the same benefits and pay the same cost sharing in the premium assistance program that they would have if they were in the state's regular Medicaid program. Thus, the cost-effectiveness determination examines the cost of providing comparable coverage either through the state's regular Medicaid program or by providing a premium subsidy—in other words these states are comparing "apples to apples." Iowa, New Jersey, and Rhode Island compare state costs for the premium subsidy plus the anticipated cost of the wraparound coverage to the cost of serving a family through the state's regular Medicaid program. In Rhode Island, for example, the cost-effectiveness test determines the maximum subsidy amount the state can pay towards the employee's share based on the actuarial value of plans popular in the private marketplace.

Because these states undertake a rigorous case-by-case cost-effectiveness analysis, they are able to say with some level of certainty that they are saving money—indeed the state would not subsidize families' coverage otherwise. As such, these states had the best available data on cost savings of those examined. New Jersey subsidizes coverage only if the state saves at least 5% compared to the cost of serving families in their regular Medicaid program. On average the state

data show that it is saving \$203.97 per family.²³ However, overall savings have been limited because only 791 family members are enrolled in the program. Rhode Island reports average savings of \$222.45 per family per month in federal and state Medicaid costs, and enrollment is substantially higher.²⁴

While these states are saving money per enrollee on a documented basis, program administrators in Rhode Island and New Jersey underscore the point that, to achieve overall savings, enrollment must be high enough to cover start-up and administrative costs. In addition, it is important to note that not all of the savings accrue to the state. Because of the federal matching payments for Medicaid and SCHIP coverage, at least half of the savings go to the federal government – the precise amount depends on the state’s matching rate.

Achieving budget certainty by capping the state’s contribution: Utah and Illinois provide fixed premium subsidies in their premium assistance programs. Because their subsidy amounts are capped, there is a level of budget certainty for federal/state payors and, as long as the subsidy amounts are set below the cost of providing direct coverage, the state should achieve savings on a per person basis. However, in Utah, enrollment is so low that it is not clear if savings from the small number of enrollees are adequate to cover start-up and administrative costs. Further, it appears that the low level of the capped subsidy may be contributing to the program’s limited enrollment. Illinois did not have data available regarding cost savings, and state officials stressed that saving money is not the intent of their program.

Assessing aggregate cost-effectiveness: Under its waiver, Oregon is only required to show that its premium assistance program is cheaper on an aggregate basis, but there are no specific terms and conditions regarding how the state should monitor this. Oregon does not have a limit on its subsidy amounts, although enrollment is capped to control overall costs. The state does not make any comparisons to ensure that it is saving money compared to its larger Medicaid waiver program, and does not have any clear data available on whether it is saving money, but believes it is saving on an aggregate basis.

In the past, Oregon primarily subsidized coverage purchased in the individual market, but the state has moved to subsidizing more group coverage largely because of cost concerns. Subsidizing coverage in the individual market is much more expensive; the most recent data available from the state shows that the average monthly state subsidy per individual enrolled in coverage purchased through the individual market is \$236.67. For individuals enrolled in group coverage, the average monthly subsidy is \$101.91.²⁵ Today approximately 40% of enrollment is in the group market, an increase from 17% prior to the waiver, according to state officials.²⁶

²³ Email communication with John Dickson, New Jersey Department of Human Services, May 6, 2005.

²⁴ Data provided by Rite Share Summary of Payments from March 2004 Financial Cycle. The average savings per family based on data from October 2003-March 2004.

²⁵ Data from 5/2/05 FHIAP snapshot of Program Activity. Available online at <http://egov.oregon.gov/IPGB/FHIAP/statistics.shtml>

²⁶ Current individual/group breakdown from 5/2/05 FHIAP snapshot. Prior enrollment statistic from email communication with Craig Kuhn, September 23, 2004.

DISCUSSION

In sum, the examined states are using a variety of approaches to implement their premium assistance programs. Most of the examined states are relying on employer contributions to help offset the cost of coverage, and they all require individual contributions from at least some relatively higher-income families. Some provide wraparound coverage, while others do not. With the exception of Oregon, the study states used two approaches for determining the cost-effectiveness of providing premium subsidies, either by assessing whether an employer contribution was sufficient to ensure cost-effectiveness on a case-by-case basis or by capping subsidy amounts. Among the study states, there was limited data available regarding cost savings, although it is evident that some states are saving money on a per enrollee basis. However, in order to achieve overall savings, enrollment must be robust enough to generate the savings necessary to cover start-up and administrative expenses. Taken together, the findings suggest the following:

Two key elements for achieving savings are an employer contribution and robust enrollment. Bringing an employer contribution into the equation offsets federal, state, and any individual costs. In addition, to achieve overall savings, enrollment must be high enough to generate enough savings to cover start-up and administrative expenses. To date, enrollment in premium assistance programs has been relatively low, likely reflecting the limited availability of affordable employer-sponsored coverage among low-income workers.

States can achieve savings without capping their subsidy amounts and while still providing wraparound coverage. The two examined states (Rhode Island and New Jersey) that clearly documented savings did not cap their subsidy amounts and provided full benefits and cost sharing protections through wraparound coverage. In the other examined states, coverage provided through the premium assistance programs may be significantly more limited than regular Medicaid or SCHIP coverage because they have few benefit and cost sharing requirements for purchased coverage and do not provide wraparound services. Further research is needed to evaluate the types of coverage being purchased under these programs and how well it meets enrollees' needs.

There is limited data available regarding cost savings. While federal policy requires premium assistance programs to be cost-effective, it does not appear that the Centers for Medicare and Medicaid Services is closely monitoring whether these programs are saving money. Neither Oregon nor Utah's Section 1115 HIFA waivers include specific terms and conditions to monitor the cost-effectiveness of their premium assistance programs. To the extent that good data is available, it is because individual states are applying rigorous methodologies to ensure state savings.

Changes in the private market impact the cost-effectiveness of premium assistance programs. Recently, there have been sharp increases in private insurance premiums. Not only have private market costs been increasing, they have been doing so more rapidly than costs in Medicaid on a per-capita basis.²⁷ If premiums in the private market continue to increase faster than the costs of

²⁷ Holahan, J. and Ghosh, A. "Understanding the Recent Growth in Medicaid Spending," *Health Affairs*, 26 January 2005.

Medicaid, and workers are asked to share a larger percentage of the growing cost, the calculation of whether it is cost-effective for states to buy families into employer-sponsored coverage becomes less and less favorable. States can limit their costs by capping their subsidy amounts, but this shifts the risk of added costs to enrollees. Low-income families, in turn, may not be able to shoulder increased costs, further limiting enrollment.

In conclusion, New Jersey and Rhode Island were able to document clear savings without capping their subsidy amounts and while still providing wraparound coverage for benefits and cost sharing. States must, however, be realistic about the potential for savings from premium assistance programs, which is limited by the scarce availability of employer-sponsored coverage for low-wage workers and relatively low levels of enrollment in those programs. Further, the ability for premium assistance programs to be cost-effective will only become more challenging over time as costs in the private market continue to rise. In the words of one state official: “One or two more years with double-digit premium increases and we may be priced out of the market.”²⁸

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²⁸ Interview with Dennis Doderer, Deputy Assistant Director, Division of Medical Assistance and Health Services, New Jersey.

APPENDIX A: SOURCES

Illinois: Phone interview and subsequent email communications with Vicki Mote, Chief Bureau of KidCare, 5/12/05. Enrollment data is as of March 31, 2005.

New Jersey: Phone interview and subsequent email communications with Dennis Doderer, Deputy Assistant Director, Division of Medical Assistance and Health Services, and John Dickson, Manager, Premium Support, 4/14/04. Enrollment and savings data as of 5/6/05 and income breakdown as of 9/21/04 based on email communications with John Dickson.

Oregon: Phone interview and subsequent email communications with Craig Kuhn, Program Manager, and Kelly Harms, Policy and Legislative Liason, Family Health Insurance Assistance Program, 5/18/04. Enrollment data and subsidy amounts from FHIAP Snapshot of Program Activity 5/2/05. Available at <http://egov.oregon.gov/IPGB/FHIAP/statistics.shtml>

Rhode Island: Phone interview with, and written materials provided by Tricia Leddy, Administrator, Center for Child and Family Health, Rhode Island Dept. of Human Services, and Kate Brewster, Employer Contact Unit Manager, Rhode Island Dept. of Human Services, 5/18/04. Enrollment data as of February 28, 2005, from John Andrews, Rhode Island Department of Human Services, 3/4/05.

Utah: Phone interview and subsequent email communications with Michael Hales, Director, Utah Primary Care Network, 4/13/04. Enrollment data and income breakdown as of 3/26/05. Income breakdown data does not equal 100% due to rounding error.

Iowa: Phone interview and subsequent email communications with Anita Smith, Chief Bureau of Health Insurance, Division of Financial, Health and Work Supports, 4/14/04. Enrollment data is as of 3/1/05, based on email communication with Kaye Kellis, Iowa Dept. of Human Services, 3/22/05.

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